Exhibit A

New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Twelve

August 18, 2020

I. Introduction

This is the twelfth semi-annual report of the Expert Reviewer (ER) under the Settlement Agreement in the case of *Amanda D. v. Sununu; United States v. New Hampshire, No. 1:12-cv-53-SM.* For the purpose of this and future reports, the Settlement Agreement will be referred to as the Community Mental Health Agreement (CMHA). Section VIII.K of the CMHA specifies that:

> Twice a year, or more often if deemed appropriate by the Expert Reviewer, the Expert Reviewer will submit to the Parties a public report on the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to be taken to facilitate or sustain compliance with the Settlement Agreement.

Community Mental Health Centers (CMHCs), remained functional and open as essential businesses during this period, and transitioned the majority of employees to remote working. Following Centers for Disease Control and Prevention (CDC) recommendations and NH Division of Public Health Services (DPHS) guidance, in addition to program specific emergency guidance provided by the Bureau of Mental Health Services (BMHS), CMHCs focused on adjusting service delivery to maintain health and to implement safety protocols while serving participants in a way that met participant needs and preferences. Telehealth services were provided for participants preferring that method due to COVID-19 concerns, and in-person services remained available for individuals who preferred this method.. Mental Health (MH) facilities, including New Hampshire Hospital (NHH), Glencliff, and residential treatment centers, modified safety protocols to protect residents/patients from COVID-19. And, State of New Hampshire officials who in regular times would be focused on implementation of the CMHA have instead been primarily focused on addressing the many challenges posed by COVID-19. The State has implemented numerous strategies, including Medicaid plan changes, eligibility certification improvements, staffing requirements, etc. to insure that to the extent possible service response rates and service continuity have been maintained. The State has also instituted new data tracking mechanisms to assess the degree to which COVID-19 has affected service access, service utilization, and hospitalization.

During the review period, the ER has been unable to conduct on-site visits or observations, other than a three-day visit to Glencliff in January. Although some Quality Service review and Fidelity Reviews have taken place during this period, the ER has not been able to observe any of these activities. More recently, because of COVID-19, there has been a break in the continuity of QSR and Fidelity review data which has been used to assess progress towards compliance with the CMHA.

The ER has participated in a number of conference calls with State officials and representatives of the Plaintiffs, as outlined below. The ER has also continued to monitor the routine monthly and quarterly data reports produced by the State, as well as newly generated data reports related to the response to COVID-19. Nonetheless, by necessity this report will be limited by the inability to have face-to-face contact with service administrators, service providers and service participants.

During this period, the ER:

- Conducted an in-depth three-day site review at Glencliff, which included reviews of 50 clinical records and interviews with senior administrators and clinical staff;
- Conducted telephone interviews with state officials to discuss state policies and activities related to facilitating transitions of residents of Glencliff into integrated community settings;
- Participated in a conference call with state leaders to discuss the State's response to COVID-19 as it relates to the mental health system;
- Convened two conference call meetings of the Parties to discuss transition planning and transitions to integrated community settings for Glencliff residents;
- Convened an All Parties conference call meeting to discuss progress in meeting the requirements of the CMHA.

Information obtained during these state level and on-site meetings has, to the extent applicable, been incorporated into the discussion of implementation issues and service performance below. When it is again possible, the ER will resume conducting site visits going forward to observe and assess the quality and effectiveness of implementation efforts and whether they achieve positive outcomes for people consistent with CMHA requirements.

Summary of Progress to Date

This report reflects more than five and one-half years of implementation efforts related to the CMHA. Within this period, a number of positive steps have been taken to improve the quality and effectiveness of services as envisioned in the CMHA. However, as will be discussed in detail below, there are areas of continued non-compliance with the CMHA. Notwithstanding these on-going concerns, the parties to the CMHA deserve credit for some real and measurable accomplishments.

As noted in previous ER reports, the State has implemented a comprehensive and reliable QSR process. The ER considers these QSR reviews to be methodologically correct and reliable, producing findings that are accurate and actionable in terms of taking concrete steps to address quality issues in the CMHC system.

Another major accomplishment has been contracting with the Dartmouth-Hitchcock Medical Center to conduct external Assertive Community Treatment (ACT) and Supported Employment (SE) fidelity reviews using nationally validated fidelity review instruments and criteria. In concert with the QSR reviews mentioned above, the fidelity reviews are assisting the State and the CMHCs to develop comprehensive Quality Improvement Plans (QIPs) that address important ACT and SE quality and effectiveness issues at both the consumer and CMHC operational levels.

Recently, following input from representatives of the Plaintiffs and the ER, the State has initiated or enhanced a number of strategies to expand ACT capacity and enrollment. Because of the impact of COVID-19 in New Hampshire, it is not possible at this time to gauge the full impact of these strategies. Recent data support mild optimism that ACT staffing is moving in a positive direction.

The parties originally envisioned that the CMHA could be fully implemented in five years, with a sixth year for maintenance of effort. The CMHA was approved and filed with the Federal Court on February 12, 2014, and the five-year anniversary of that event occurred 17 months ago. The ER was approved by the Parties and the Federal Court effective July 1, 2014, and the five-year anniversary occurred 12 months ago. Given these elapsed times, it is critical for this report and for subsequent activities that the focus be on specific strategies and action steps necessary to meet the requirements of the CMHA, and to plan for disengagement.

II. Data

As noted in previous reports, the New Hampshire Department of Health and Human Services (DHHS) continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (January 2020 through March 2020), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The capacity to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve. The ER continues to emphasize that the State must produce the necessary data reports in a timely fashion.

III. CMHA Services

The following sections of the report address specific service areas and related activities and standards contained in the CMHA.

Mobile/Crisis and Crisis Apartment Programs

The CMHA calls for the establishment of a Mobile Crisis Team (MCT)[1] and Crisis Apartments (MCT/CA) in the Concord Region by June 30, 2015 (Section V.C.3(a)). DHHS conducted a procurement process for this program, and the contract was awarded on June 24, 2015. Riverbend CMHC was selected to implement the MCT and Crisis Apartments in the Concord Region.

The CMHA specified that a second MCT/CA program be established in the Manchester region by June 30, 2016 (V.C.3(b)). The Mental Health Center of Greater Manchester was selected to implement that program. Per CMHA V.C.3(c), a third MCT/CA program became operational in the Nashua region on July 1, 2017. The contract for that program was awarded to Harbor Homes in Nashua.

As of the date of this report, the State reports that it has extended the existing MCT/CA program contracts in Riverbend (Concord) and Manchester until June 2022. The State reports it has incorporated contract changes for these programs including: (a) new performance measures related to face-to-face assessments and follow-up engagement with peers; and (b) new data reporting elements related to presenting problems, police involvement, and intervention outcomes. The ER will monitor implementation of these new requirements over the next six month period.

The vendor in Nashua (Harbor Homes) is reported to have opted out of its contract. To assure continuity of services, the State reports it has extended the current Nashua contract for four months, during which time a new vendor will be sought. The ER intends to monitor this situation closely over the next six months.

The Quarterly Data Report contained in Appendix A includes a detailed table of data from each of the Mobile Team/Crisis Apartment programs. Table I contains a summary of key data trends from the three programs.

[1] Note that the State refers to these programs as Mobile Crisis Response Teams (MCRTs). The ER uses the MCT nomenclature to remain consistent with the terms used in the CMHA.

Table I

Self-Reported Data on Mobile Crisis Services and Crisis Apartment Programs

Region	Variable	April -June 2019	July - Sept. 2019	Oct. - Dec 2019	Jan. - Mar. 2020
Concord	Total Served	517	499	516	531
Manchester	Total Served	714	679	604	618
Nashua	Total Served	419	377	368	333
Concord	Phone triage/support	1,143	1,104	1,139	1,173
Manchester	Phone triage/support	1,795	1,833	1,482	1,565
Nashua	Phone triage/support	522	530	463	385
Concord	Mobile Assess./intervention	136	211	149	116
Manchester	Mobile Assess./intervention	319	280	303	290
Nashua	Mobile Assess./intervention	245	231	189	210
Concord	Percent Referred by self	68.8%	61.6%	56.39%	64.22%
Manchester	Percent Referred by self	31.8%	36.7%	75.7%	68.2%
Nashua	Percent Referred by self	27.4%	29.8%	41.12%	34.23%
Concord	Percent referred by police	1.8%	3.7%	5.04%	4.33%
Manchester	Percent referred by police	28.2%	25.4%	37.25%	33.0%
Nashua	Percent referred by police	2.7%	2.1%	4.62%	3.60%
Concord	Percent Law Enforcement Inv.	14.1%	12.6%	5.00%	8.70%
Manchester	Percent Law Enforcement Inv.	44.8%	40.2%	37.25%	33.0%
Nashua	Percent Law Enforcement Inv.	0.0%	0.0%	0.00%	0.00%
Concord	Hospital diversions	449	520	483	383
Manchester	Hospital diversions	1,185	1,111	1,086	1,088
Nashua	Hospital diversions	704	710	612	617
Concord	Apartment Admits	80	78	81	57
Manchester	Apartment Admits	15	9	18	17
Nashua	Apartment Admits	51	53	48	56
Concord	Apartment bed days	319	397	364	245
Manchester	Apartment bed days	46	27	72	53
Nashua	Apartment bed days	249	306	252	296

Table II below includes data that reveal some recent changes in both emergency department waiting times for NHH admissions, and for NHH readmission rates. These data may indicate that the fully implemented MCT and Crisis Apartment programs have a positive effect on system indicators such as emergency department boarding and hospital recidivism rates. However, there may be numerous other factors influencing these data trends.

Table II
DHHS Report of Changes in Waiting Time for NHH Admissions and NHH Readmission Rates

12-month Period	Average # Adults Waiting per Day for NHH Admission	NHH Admissions	NHH 180-day Readmissions Average
4/1/18 – 3/31/19	44	788	24%
4/1/19 – 3/31/20	29	938	21.9%
Change	Down 34%	Up 19%	Down 8.8%

The ER continues to be concerned about some apparent practice and data reporting variations among the three MCT/CA programs. For example, as can be seen in Table I, there are substantial differences among the three programs with regard to police referrals to and law enforcement involvement in the various programs. Late last year, in concert with representatives of the plaintiffs, the ER requested additional information from the State regarding the functioning of these programs. While the State reports conducting visits to the MCT/CA program sites, no performance assessments or other contractual reviews/program evaluations or QIPs (if applicable) have been published or shared with the ER or the parties. The ER expects additional State oversight and/or corrective action on the part of the MCT/CA programs, including an effort to measure program performance in key areas of MCT service delivery, like phone triage, decisions to deploy mobile crisis teams to community locations, and the efficacy of crisis response.

The State has issued an RFI related to MCT/CA programs, and responses have been received by the State as of the date of this report. The State asserts that the RFI indicates that it is "actively engaged in a comprehensive effort to explore best practices and model designs for MCT services, and we anticipate this effort also will inform the next contracts for the MCTs required under the CMHA." [2] The ER previously recommended that the parties collectively review the responses to the RFI and that the ER and representatives of the Plaintiffs engage in discussions with the State about current program operations and future operations of MCT and similar programs in New Hampshire. The State has just recently shared the responses to the RFI with

[2] State response to ER memo re: MCTs, December 12, 2019, page 1.

the ER and representatives of the Plaintiffs. To date there have not been any substantive discussions among the Parties to the CMHA about future directions for the MCT/CA programs, but the ER expects that will occur after there has been sufficient time to review the RFI responses. Given the need to select a new vendor for the greater Nashua area, the ER expects these conversations to occur before October 1, 2020.

The State recently funded a new Behavioral Health Crisis Treatment Center (BHCTC) that has been implemented by the Riverbend CMHC in Concord. The BHCTC is an additional crisis support outside those required by the CMHA. As such, data related to the operations of that program is not included in this report. The State asserts that it is not currently considering this model for expansion of crisis programs in New Hampshire.

Assertive Community Treatment (ACT)

ACT is a core element of the CMHA, which specifies, in part:

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team;
3. By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,500 individuals in the Target population at any given time; and
4. By June 30, 2017, the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but not available, and develop effective regional and statewide plans for providing sufficient ACT services to ensure reasonable access by eligible individuals in the future.

The CMHA requires a robust and effective system of ACT services to be in place throughout the state as of June 30, 2015 (60 months ago). Further, as of June 30, 2016, the State was required to have the capacity to provide ACT for 1,500 priority target population individuals.

As displayed in Table III below, the staff capacity of the 13 adult ACT teams in New Hampshire has increased by 4.47 FTE since June of 2019. However, this represents a reduction of 3.9 FTE since December of 2019. It should be noted that this is a decrease of .08 FTE since September, 2017.

Table III

Self-Reported ACT Staffing (excluding psychiatry):

September 2017 – March 2020

Region	FTE Sep-17	FTE Mar-19	FTE Jun-19	FTE Sep-19	FTE Dec-19	FTE Mar-20
Northern	12.4	16.8	16.51	16.37	16.97	16.37
West Central	7.0	6.8	7.65	8.25	8.75	6.10
Lakes Region	10.8	8.3	8.00	8.00	7.00	7.00
Riverbend	10.0	11.5	10.50	11.50	11.50	10.50
Monadnock	7.9	9.5	9.00	8.00	8.75	8.85
Greater Nashua 1	6.0	6.5	7.00	8.00	8.00	6.50
Greater Nashua 2	5.0	4.5	4.00	7.00	8.00	7.50
Manchester – CTT	16.3	14.3	15.75	15.75	15.75	18.25
Manchester MCST	22.3	15.8	17.25	17.25	15.75	16.25
Seacoast	10.5	9.1	9.10	10.10	10.10	9.10
Community Part.	6.7	8.8	10.78	11.28	10.80	11.05
CLM	9.3	7.9	7.01	8.30	9.55	8.55
Total	124.2	119.6	122.55	129.80	130.92	127.02

Two teams (West Central and Nashua 1) report having fewer than the required minimum of seven FTEs to qualify as an ACT team. Two teams (Riverbend and Community Partners) report having no peer support specialist. One team (Nashua 2) reports having no SE staff capacity. Five teams report having 0.5 or less FTE combined psychiatry/nurse practitioner time available to their ACT teams[3]; and five of the 12 teams report having less than one FTE nurse per team.

Table IV below displays the active ACT caseloads by CMHC Region since June 2017. Note that, for economy of presentation, data for the reporting periods from December 2017 through April 2019 have been excluded from the table. The active monthly caseload has decreased by 31 participants since December, 2019. Since June of 2017 the active monthly caseload has dropped by 103.

[3] The CMHA specifies at least 0.5 FTE Psychiatrists for teams with at least 70 active service participants. (CMHA V.D.2(e)).

Table IV

Self-Reported ACT Active Caseload (Unique Adult Consumers) by Region in Specified Months: June 2017 – March 2020

Region	Active Cases Jun-17	Active Cases Sep-17	Active Cases Jun-19	Active Cases Sep-19	Active Cases Dec-19	Active Cases Mar-20
Northern	111	113	115	122	118	115
West Central	76	68	46	47	43	42
Lakes Region	74	74	57	56	56	57
Riverbend	97	87	102	86	94	94
Monadnock	70	69	57	49	50	51
Greater Nashua	94	98	83	97	99	101
Manchester	292	287	287	300	286	262
Seacoast	69	67	66	68	65	66
Community Part.	69	75	67	71	74	68
CLM	55	54	47	49	50	47
Total*	1,006	992	925	942	934	903

* unduplicated across regions

The combined ACT teams have a reported March 2020 staff complement of 127.02 FTEs excluding psychiatry, which is sufficient capacity to serve 1,270 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA. However, with a statewide caseload of only 903, as of March 2020, there is a gap between staff capacity and active participants of 367.

As noted above, the CMHA requires the State to have capacity to serve 1,500 individuals. The current ACT staffing levels are 23 FTEs, (or capacity to serve 230 participants), below the capacity required by the CMHA. This gap between staff capacity and actual service participants is particularly problematic, given that there are reported to be 10 individuals on the wait list for ACT (see Table VII below). The State reports that all 10 are awaiting services from one of the two teams in Manchester, but State data reveals that the two teams in Manchester have unused ACT staffing capacity that could accommodate 83 new individuals right now. There appears to be no staffing explanation to justify the waitlist. An additional 15 individuals are reported to have been referred for ACT services, but they are awaiting a CMHC determination of appropriateness for ACT. It is not clear why there is a delay determining ACT appropriateness. ***As noted in previous reports, the current level of ACT staffing is not sufficient to meet CMHA requirements for ACT team capacity. Furthermore, the current ACT caseload of 903***

individuals is 597 below the number that could be provided ACT services with the staffing capacity required by the CMHA.[4]

ACT Screening

As has been documented in previous reports, the State has been implementing a number of strategies to increase ACT enrollment and participation. One of these strategies has been to require the ten CMHCs to conduct and report regular clinical screening for eligibility/appropriateness for ACT services. The clinical screens are conducted:

1. As part of the intake process at the CMHCs; [5]
2. Upon referral to a CMHC following discharge from an inpatient facility; and
3. As part of regular quarterly and annual assessments and plan of care amendments for current CMHC clients[6] who may qualify for and benefit from ACT.

Table V below presents data on ACT screens conducted by CMHCs between October and December, 2019.

[4] The ER notes that active ACT caseload is a static measure of ACT activity. The ER plans to work with the State and representatives of the Plaintiffs to incorporate other indicators, such as ACT enrollments and unduplicated ACT participants in subsequent reports.

[5] Note that a CMHC intake incorporating the ACT screen is performed when a CMHC emergency services staff or Mobile Crisis Team encounters and refers a person potentially needing CMHC services. In some cases, these Emergency Services/ MCT referrals are made on behalf of individuals who have presented in crisis in hospital emergency departments and who may be waiting for a NHH admission.

[6] Until recently, data on the total number of ACT screenings included current ACT participants. Active ACT clients have now been removed from screening reports.

Table V

Self-Reported Number of Unique Clients Screened for ACT Services by CMHCs

October - December 2019[7]

Community Mental Health Center	Total Screened	Appropriate for further ACT Assessment	Receiving ACT/ w/i 90 days of Assessment	Percent Receiving ACT of those Qualified for Assessment	Percent Receiving ACT in Previous Report
01 Northern Human Services	1,166	21	2	9.5%	10%
02 West Central Behavioral Health	221	2	2	100%	0.0%
03 Lakes Region Mental Health Center	906	11	1	9.1%	0.0%
04 Riverbend Community Mental Health Center	1,342	13	2	15.4%	0.0%
05 Monadnock Family Services	576	3	0	0.0%	0.0%
06 Greater Nashua Mental Health	726	6	1	16.7%	62.5%
07 Mental Health Center of Greater Manchester	1,641	7	1	14.3%	0.0%
08 Seacoast Mental Health Center	1,392	48	0	0.0%	0.0%
09 Community Partners	434	0	0	0.0%	0.0%
10 Center for Life Management	779	2	0	0.0%	0.0%
Total	**9,183**	**113 (1.2% of all screened)**	**9 (7.96% of all assessed after screening- 0.1% of all screened)**		

[7] The most recent Quarterly Data Report contains screening data only through December 2019.

Of the 9,183 unique individuals screened for ACT during this period, the State reports that 113 were referred for an ACT assessment. This is a referral rate of one percent. And, less than 8 percent (nine individuals) of those referred for ACT assessments were enrolled in ACT services within 90 days of being screened. Most of the referrals for ACT screening are internal to the CMHCs. That is, people who have already had a CMHC intake, and who may already be receiving CMHC services, are those most likely to be screened for ACT services. Thus, it is perhaps not surprising that so few of the individuals screened are referred to the next step, which is the assessment for ACT.

The State has reported that about 88% of individuals are linked to ACT without having gone through the ACT screening process. No specific data have been reported to date about where these referrals originate or how they avoided the CMHC intake and screening process. Because of this limitation, available screening data does not shed light on whether individuals outside of the CMHC system who would benefit from ACT services are being properly identified and referred for assessment.

New ACT Clients

The State has recently begun reporting the number of new ACT clients. Table VI summarizes these data from the two most recent reporting periods.

Table VI

Self-Reported New ACT Clients

CMHC	New Clients October 2019 – December 2019	New Clients January 2020 – March 2020
Northern Human Services	6	10
West Central Behavioral Health	11	6
Lakes Region MHC	5	4
Riverbend CMHC	20	13
Monadnock Family Services	1	1
Greater Nashua Mental Health	6	8
MHC of Greater Manchester	17	19
Seacoast MHC	3	4
Community Partners	5	4
Center for Life Management	3	1
Total	**77**	**70**

It should be noted that in the time period from October to December, 2019, the State reported a decrease in active ACT caseload from 958 to 934, while at the same time reporting the addition of 77 new ACT clients. For the period January through March, 2020, the State reported that the ACT active caseload decreased from 929 to 903, while at the same time reporting the addition of 70 new ACT clients. This indicates that: (1) there is substantial turnover in the active ACT caseload over a relatively short time frame; and (2) thus, substantial efforts to engage new ACT clients are necessary just to maintain steady state operations in the ACT program, much less to grow the program. Indeed, for the January-March 2020 review period, the State reports that while 70 new ACT clients were added, over 100 were discharged from, or otherwise dropped out of, ACT services. The ER notes that the State does not currently report on dispositions for individuals who leave ACT services. This is an important topic for future discussions and reporting, especially with regard to any former ACT clients who then suffer decline or crisis after ACT services are terminated.

The State has been reporting data on the number of individuals waiting for ACT services on a statewide basis for the past 18 months. This information is displayed in Table VII below. The State and the CMHCs assert that an individual eligible for ACT may have to wait for ACT services because the specific ACT team of the individual's CMHC does not currently have staff capacity to accept new clients. The ER has documented above that there is a statewide gap between ACT staff capacity and ACT participation. Indeed, there is excess capacity in each region/team and enough capacity to address the needs of people reported to be on the waitlist. Nonetheless, the State and the CMHCs note that in some CMHC regions, new ACT staff must be hired before new ACT clients can be accepted into the program.

Table VII

Self-Reported ACT Wait List

		Time on List		
	Total	**0-30 days**	**31-60 days**	**61-180 days**
December 31, 2018	6	3	0	3
March 31, 2019	2	1	1	0
June 30, 2019	1	1	0	0
September 30, 2019	2	2	0	0
December 31, 2019	5	2	2	1
March 31, 2020	10	0	3	7

The ER notes that all 10 individuals reported to be on the wait list for ACT services have been waiting for greater than 30 days: seven of the 10 have been waiting for more than 60 days. Given the excess ACT capacity noted above, the ER expects the State will intervene to assure that people in need of, and eligible for, ACT receive ACT services in a timely manner.

New Hampshire Hospital (NHH) Admissions and Discharge Data Relative to ACT

In concert with other strategies to improve access to ACT services, the State has begun tracking the extent to which individuals on ACT are admitted to NHH; are referred to ACT from NHH; and are accepted into ACT upon discharge from NHH. Table VIII summarizes data from the past two quarters on these issues.

Table VIII

Self-Reported Total ACT-Related Admissions to and Discharges from NHH

October 2019 through March 2020

	On ACT at admission	Percent of all Admissions	Referred to ACT on Discharge	Percent of all Discharges	Accepted into ACT on Discharge	Percent of Those Accepted into ACT on Discharge
Oct.-Dec 2019	64	38.1%	25	24.0%	14	56.0%
Jan.-Mar. 2020	53	35.1%	28	28.6%	11	39.3%

In concert with tracking admissions to and discharges from NHH related to ACT, the State has begun reporting the reasons that individuals are not accepted into ACT upon discharge from NHH. Table VIX summarizes this reported information.

Table VIX

Self-Reported Reasons Not Accepted into ACT upon Discharge from NHH

October 2019 through March 2020

Reason Not Accepted into ACT on Discharge	October – December 2019	January – March 2020
Not Available in Individual's Town of Residence	0	0
Individual Declined	1	0
Individual's Insurance does not Cover ACT	0	0
Does not Meet ACT Clinical Criteria	2	1
Individual Placed on ACT Wait List	0	1
Individual Awaiting CMHC Determination for ACT	8	15
Total Unique Clients	11	17

In the January – March 2020 time period almost 90% of the individuals referred but not accepted into ACT on discharge from NHH were reported to be awaiting CMHC determination of ACT. In the October – December time period this number was almost 75% of the total individuals referred but not accepted into ACT. This means that the long elapsed time for CMHCs to determine ACT appropriateness has been the most prevalent reason why people referred for ACT have not yet received it post NHH discharge. The ER remains concerned about these reported delays in accessing ACT services at the CMHC level. This concern is in addition to concerns about the number of people reported to be waiting more than 30 days for access to ACT services.

The ER understands that the State has been attempting to improve referrals to and acceptance in ACT services, and has implemented directed payments and other incentives to improve performance in this area. However, currently reported data does not support a conclusion that access has in fact been improved. Thus, the ER expects the state to take additional steps to align the reported excess capacity in the ACT system with the needs of individuals for ACT services, both on discharge from NHH and from the ACT waiting list. By October 15, 2020 the ER expects a written report from the state on: (1) the action steps being taken to address delays in accessing ACT services; and (2) the actual numerical progress being made to assure that individuals eligible for and in need of ACT, including those being discharged from NHH, receive timely access to these services.

ACT Fidelity and Quality

Limitations on ACT Fidelity reviews have been imposed because of COVID-19. Thus, there is limited fidelity information available for this report.

ACT Summary Findings

Based on the above information, the ER finds that the State remains out of compliance with the ACT service standards described in Section V.D. of the CMHA. The State does not currently provide a robust and effective system of ACT services throughout the state as required by the CMHA.

The ER emphasizes, as in past reports, that it must be the first priority of the State and the CMHCs to focus on: (1) assuring required ACT team composition; (2) utilizing existing ACT team capacity; (3) reducing the number of individuals on the ACT wait list and/or awaiting ACT services upon discharge from NHH, as well as reducing the length of time individuals are waiting for ACT services; and (4) markedly improving outreach to and enrollment of new ACT clients.

Supported Employment (SE)

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for SE (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2017, the State will increase its penetration rate of individuals with SMI receiving supported employment … to 18.6% of eligible individuals with SMI." (Section V.F.2(e)). In addition, by June 30, 2017, "the State will identify and maintain a list of individuals with SMI who would benefit from supported employment services, but for whom supported employment services are unavailable" and "develop an effective plan for providing sufficient supported employment services to ensure reasonable access to eligible individuals in the future." (V.F.2(f)).

As noted in Table X below, seven of the ten CMHCs now report penetration rates lower than the CMHA requirement. This is an increase in the number of CMHC regions reporting SE penetration below the CMHC standard. In the previous reporting period, six CMHC regions reported being below the state standard of 18.6% penetration. **While the State continues to meet the statewide standard for SE penetration in the CMHA, this is primarily due to strong SE penetration rates in two CMHC Regions (Manchester (41.7%) and Seacoast (39%). The ER is increasingly concerned that target population members in large portions of New Hampshire are reported to not have adequate or equitable access to this essential best practice service.**

Table X

Self-Reported CMHC SE Penetration Rates

	Penet. Jun-19	Penet. Sep-19	Penet. Dec-19	Penet. Mar-20
Northern	14.90%	15.80%	15.00%	14.20%
West Central	22.50%	19.70%	20.10%	22.20%
Lakes Reg.	18.90%	18.90%	19.60%	15.90%
Riverbend	19.00%	18.40%	17.40%	16.20%
Monadnock	6.80%	6.20%	6.20%	7.30%
Greater Nashua	13.10%	12.7%	13.00%	15.10%
Manchester	39.00%	39.30%	40.50%	41.70%
Seacoast	33.70%	32.90%	34.20%	39.00%
Community Part.	8.60%	7.80%	10.10%	11.70%
CLM	20.80%	20.10%	18.00%	16.40%
CMHA Target	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	**23.50%**	**23.20%**	**23.70%**	**23.70%**

The State reports data on the degree to which CMHC clients are working, either full or part time, in competitive employment.[8] Access to competitive employment is an important indicator of the quality and effectiveness of fidelity model SE services. Table XI summarizes some key findings from these data reporting efforts.

[8] State data defines full time employment as working 20 hours a week or more. The statewide percentage of SE users in full-time employment in the quarter ending September 30, 2019 was 6.0%.

Table XI

Self-Reported Competitive Employment for CMHC Clients Who Recently Used SE Services

CMHC	Percent of SE Active Clients Employed Full or Part Time July – September 2019	Percent of SE Active Clients Employed Full or Part Time Jan – March 2019	Percent of SE Active Clients Employed Full or Part Time Oct. Dec 2019	Percent of SE Active Clients Employed Full or Part Time Jan. – Mar. 2020
Northern	38.9%	44.2%	34.4%	40.5%
WCBH	28.6%	43.8%	42.1%	45.4%
LRMHC	34.9%	27.9%	53.0%	40.6%
Riverbend	60%	61.8%	64.3%	54.0%
Monadnock	40%	52.0%	64.7%	36.4%
Nashua	38.9%	31.9%	37.8%	44.8%
MHCGM	58.3%	54.3%	54.0%	52.0%
Comm. Prtnrs.	53.9%	57.1%	50.0%	42.8%
Seacoast	36.3%	31.3%	32.3%	28.3%
CLM	75%	56.5%	78.1%	63.3%
Statewide	49.2%	46.7%	51.9%	46.7%

For those eligible adults not involved in SE, the overall numbers are lower, with only 26.9% currently engaged in full-time or part-time employment statewide.

These data provide a reasonable baseline for future analyses. At this point, there do not appear to be substantial changes in the degree to which SE participants are accessing full or part time competitive employment. The ER will continue to review these competitive employment data in concert with the available SE fidelity and QSR reports.

The State reports that 54 individuals are waiting for SE services – 43 individuals (or 80 percent) have been waiting for over a month. This must be addressed to "ensure reasonable access to eligible individuals" per CMHA V.F.2(f).

SE Fidelity and Quality

As with ACT services, the limitations created by COVID-19 have prevented SE fidelity reviews from being conducted during much of the time frame covered by this report. The ER is hopeful

that quality and fidelity reporting related to SE services can be resumed for the next reporting period.

Supported Housing (SH)

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Program and HUD-funded subsidies by June 30, 2016. As of March, 2020, the State reports having 327 individuals leased in Bridge Program subsidized units and 94 people approved for a Bridge Program subsidy, but not yet leased. This 94 figure is high compared to past totals and seems to indicate that there may be an execution problem somewhere in the system. The State has not provided any localized data per region to expose the location of any problems with getting individuals into leased apartments. There are 49 individuals reported to be on the Bridge Program wait list as of the end of March, 2020. Of these, 18 individuals have been on the wait list for more than two months. There has been a precipitous drop in the aggregate number of individuals either leased or approved but not yet leased in the Bridge Program – from 591 in June of 2017 to 421 in March, 2020; the current number with leases being paid is only 327.

Table XII below provides data regarding the number of current Bridge Subsidy participants; the number waiting to lease; the number on the Bridge Subsidy waiting list; the total number leased since the inception of the program; and the total number receiving a HUD Housing Choice Voucher (HCV). Table XIII provides quarterly data regarding the number of Bridge Subsidy program applications and terminations.

Table XII

New Hampshire DHHS Self-Reported Data on the Bridge Subsidy Program:

June 2017 through March 2020

Bridge Subsidy Program Information	June 2017	Sept. 2018	March 2019	June 2019	Sept. 2019	Dec. 2019	March 2020
Total individuals leased in the Bridge Subsidy Program	545	423	389	365	338	340	327
Individuals in process of leasing	46	0	11	13	35	54	94
Individuals on the wait list for a Bridge Subsidy[9]	0	35	38	44	42	25	49
Total number served since the inception of the Bridge Subsidy Program	701	811	812	812	829	872	922
Total number transitioned to a HUD Housing Choice Voucher (HCV)	85	125	137	133	151	163	179

[9] The State did not maintain a waitlist prior to 2018.

Table XIII

Self-Reported Housing Bridge Subsidy Applications and Terminations

Measure	January – March 2019	April – June 2019	July-September 2019	October – December 2019	January – March 2020
Applications Received	29	28	22	59	74
Point of Contact					
CMHCS	22	11	13	51	63
NHH	5	14	9	8	11
Other	1	1	0	0	0
Applications Approved	14	14	11	42	104
Applications Denied	0	1	0	0	0
Denial Reasons	*NA*	0	*NA*	*NA*	*NA*
Applications in Process at end of period	53	74	75	79	49
Terminations	1	0	0	0	2
Termination Reasons	1	*NA*	*NA*	*NA*	*Not Reported*
Over Income					

The CMHA stipulates that "…all new supported housing …will be scattered-site supported housing, with no more than two units or 10 percent of the units in a multi-unit building with 10 or more units, whichever is greater, and no more than two units in any building with fewer than 10 units known by the State to be occupied by individuals in the Target population." (V.E.1(b)). Table XIV below displays the reported number of units leased at the same address.

Table XIV

Self-Reported Housing Bridge Subsidy Concentration (Density)

	Decem-ber 2018	**March 2019**	**June 2019**	**Sept. 2019**	**Dec. 2019**	**Mar. 2020**
Number of properties with one leased SH unit at the same address	329	315	300	282	276	279
Number of properties with two SH units at the same address	27	18	16	18	18	14
Number of properties with three SH units at the same address	4	3	4	1	4	2
Number of properties with four SH units at the same address	3	2	2	1	2	2
Number of properties with five SH units at the same address	1	2	1	1	0	0
Number of properties with six SH units at the same address	0	0	0	0	0	0
Number of properties with seven+ SH units at same address	2	1	1	1	1	1

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)). DHHS reports that there is currently only one voluntary roommate occurrence among the currently leased Bridge Subsidy Program units in the above data.

As noted in the ER Reports dating back to 2016, DHHS was working on a method to cross-match the Bridge Subsidy Program participant list with the Phoenix II and Medicaid claims data. Table XV summarizes the most recent iterations of these data.

Table XV

Self-Reported Housing Bridge Subsidy Program Tenants Linked to Mental Health Services

	As of 3/31/19	As of 6/30/19	As of 9/30/19	As of 12/31/19	As of 3/31/2020
Housing Bridge Tenants Linked to Mental Health Services	337 of 400 (84.5%)	360 of 378 (95%)	339 of 373 (91%)	358 of 394 (91%)	348 of 421 (83%)

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports.[10]

The CMHA also states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain federal Department of Housing and Urban Development (HUD) funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)). In 2015, New Hampshire applied for and was awarded funds to develop a total of 241 units of supported housing under the HUD Section 811 Program (191Program Rental Assistance [PRA] and 50 Mainstream). All of these units are to be set aside for people with serious mental illness. As of the date of this report, 119 (combined PRA and Mainstream) of these new units are reported to have been developed and to have been occupied by members of the target population. The State has not been able to provide the current number of people in 811 housing, only the cumulative total over time.

It should be noted that over the life of the Bridge Program the State has accessed 180 HUD Housing Choice Vouchers (HCVs) and five HUD public housing or similar subsidized units.

The CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing." (V.E.3(f)). As referenced above, there are currently reported to be 49 individuals on the wait list for the Bridge program; 18 of these individuals have been on the wait list for more than two months. The State has

[10] Some of these tenants might be receiving services from MH providers other than a CMHC.

recently submitted additional information about the status of individuals on the wait list. This report has not yet been discussed with representatives of the Plaintiffs or with the ER. The ER understands that the State is making efforts to assist people on the wait list to attain housing, but it is not yet possible to verify that the State complies with CMHA requirements with regard to the supported housing wait list.

The State has also recently supplied information on the total capacity of supported housing units dedicated to the target population of the CMHA in New Hampshire. This information has not yet been discussed with representatives of the Plaintiffs or the ER. Until this information is verified and accepted by the parties, the ER is not able to document that the State meets CMHA requirements with regard to supported housing capacity.

The ER intends to schedule a conference call with state officials and representatives of the Plaintiffs to discuss this new information by October 15, 2020.

The State has recently implemented a major change in the administration of the Housing Bridge Subsidy program. Previously, the program had been administered on a statewide basis by an independent contractor. Under the new model, each of the ten CMHCs will perform certain participant-level functions, such as housing search; lease-up and occupancy supports; landlord negotiations; arrangement of housing related services and supports, and eviction prevention. The CMHCs will also directly pay rent subsidies to landlords and will be reimbursed for these costs by the State. The State will manage intake and eligibility determination functions and will maintain a statewide waiting list.

These administrative changes could have an impact on the overall effectiveness of the Housing Bridge Subsidy Program. However, it is too early in the implementation process to assess the effects of these changes. The ER will continue to monitor the implementation process as well as monitoring data regarding lease-ups, the waiting list, and other related performance data.

Transitions from Institutional to Community Settings

During the past 70 months, the ER has visited both Glencliff and NHH on at least ten separate occasions to meet with staff engaged in transition planning. The ER has participated in six meetings of the Central Team. The CMHA required the State to create a Central Team to overcome barriers to discharge from institutional settings to community settings. The Central Team has now had about 58 months of operational experience. As of June, 2020, 63 individuals have been submitted to the Central Team, 41 from Glencliff and 22 from NHH. Of these, the State reports that 30 individual cases have been resolved,[11] two individuals are deceased, and 31

[11] Five of these individuals were readmitted to NHH after 90 days and five of these have returned to community settings as of this report.

individual cases remain under consideration. Table XVI below summarizes the discharge barriers that have been identified by the Central Team with regard to these 31 individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total higher than the number of individuals reviewed by the Central Team.

Table XVI

Self-Reported Discharge Barriers for Open Cases Referred from NHH and Glencliff to the Central Team:

June 2020

Discharge Barriers	Glencliff	NHH
Legal	6 (23.1%)	2 (40.0%)
Residential	22 (84.6%)	4 (80.0%)
Financial	12 (46.1%)	2 (40.0%)
Clinical	20 (76.9%)	5 (100%)
Family/Guardian	15 (57.7%)	3 (60.0%)
Other	1 (0.04%)	1 (20.0%)

Glencliff

In the time period from October 2019 through March 2020, Glencliff reports that it has admitted nine individuals, and has had two discharges and four deaths. The average daily census through this period was 111 people. There have been no readmissions during this time frame. The mean overall wait list for admission has remained relatively constant at 26 to 29 people for the past six months.

CMHA Section VI requires the State to develop effective transition planning and a written transition plan for all residents of NHH and Glencliff (VI.A.1), and to implement them to enable these individuals to live in integrated community settings. In addition, Section V.E.3(i) of the CMHA also requires the State by June 30, 2017 to: "…have the capacity to serve in the community [a total of 16][12] individuals with mental illness and complex health care needs

[12] Cumulative from CMHA V.E.(g), (h), and (i).

residing at Glencliff…." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing."[13]

DHHS reports that a total of 19 people have transitioned from Glencliff to integrated settings since the inception of the CMHA five years ago. Based on data supplied by the State for the previous report, there are currently 30 individuals undergoing transition planning who could be transitioned to integrated community settings once appropriate living settings and community services become available. Nine of these individuals have been assigned to Choices for Independence (CFI) waiver case management agencies in order to access case management in the community to facilitate transition planning, and four are currently in the application process. Three individuals have been found eligible for the Acquired Brain Disorder (ABD) or Developmental Disability (DD) waivers, and two have been denied eligibility for these waivers. Four individuals are reported to not meet criteria for referrals to one or more of the waivers. The remaining seven individuals may meet criteria for CFI, but have not applied for case management, as an appropriate placement type to meet their needs has not yet been determined.

DHHS continues to provide information about Glencliff transitions at the time of discharge, including clinical summaries, lengths of stay, location and type of community integrated setting, and array of individual services and supports arranged to support them in integrated community settings. This information is important to monitor the degree to which individuals with complex medical conditions that could not be cost-effectively served in SH continue to experience transitions to integrated community settings. To protect the confidentiality of individuals transitioned from Glencliff, this person-specific information is not included in the ER reports.

DHHS has initiated action steps to enhance the process of: (a) identifying Glencliff residents wishing to transition to integrated settings; and (b) increasing the capacity, variety and geographic accessibility of integrated community settings and services available to meet the needs of these individuals. Both sets of initiatives are intended to facilitate such community transitions for additional Glencliff residents. Despite these efforts, transitions to integrated community settings from Glencliff have slowed in the past 30 months.

The ER remains very concerned about the slow pace of transitions to integrated community settings by residents of the Glencliff Home. Based on this concern, the ER conducted a three-day on-site review during the month of January. This review focused on the following CMHA provisions specifically relevant to transitions planning and effectuating transitions to integrated community settings on the part of Glencliff residents:

> Section VI.A.1 "The State, through its community mental health providers and/or other relevant community providers, will provide *each* individual in NHH and Glencliff with effective transition planning and a written transition plan …." (Emphasis added);

[13] CMHA V.E.2(a).

Section VI.A.2 (a) through (e). Note that Section (e) states: that transition planning will "not exclude any individual from consideration for community living based solely on his or her level of disability";

Section VI.A.4 , which states, in part: "... the State will make all reasonable efforts to avoid placing individuals into nursing homes or other institutional settings";

Section VI.A.7 and 8, which require the State to implement a system of in-reach activities to enable Glencliff residents to develop relationships of trust with CMHCs and other providers and to actively support residents to transition to the community with proactive efforts to educate residents and family members/guardians about community options; and

Section V.E.2 (a) and (b) and Sections V.E.3(g) through (j), which require the State to develop integrated community living options for individuals with complex health care needs according to an implementation schedule and wait list provisions.

Steps Taken

During the on-site visit the ER completed a review of case files and transition plans for a total of 50 residents of Glencliff. One of these 50 transitioned to the Palm Street program in Nashua on the last day of record reviews, so the current review group is now 49. There are two social workers at Glencliff who manage the transition planning process. These individuals carry "caseloads" of residents who have indicated a desire to transition out of Glencliff, and they also work with most other residents to engage them in transition option discussions. There are currently 28 residents on the Active Transition Planning list. The two social workers identified an additional cohort of 21 residents who, in their judgment, were examples of residents who could be in the active transition planning cohort if they would indicate a desire to transition out of Glencliff. The basic mechanism for identifying residents for the active transition planning list is their response to Section Q of the Minimum Data Set (MDS) form. In the table below, residents who answered "yes" on Section Q are in the Active Transition Planning cohort; residents who answered "no" on the Section Q are in the second, non-active cohort.

Table XVII below provides a summary of the case files reviewed:

Table XVII

Glencliff Transition Planning Case Record Review

	Social Worker A	Social Worker B	Total
Residents on Active Transition Planning List	16	12	28
Residents with Potential to Be on the Active Transition Planning List	10	11	21
Total	**26**	**23**	**49**

The ER also completed the following interviews:

1. Case by case discussion of each case file reviewed with the assigned case manager and the Glencliff manager with overall responsibility for admission, continuing stay, and transition from Glencliff;
2. Discussion with the administrative and clinical leadership of Glencliff regarding the overall transition planning process, including internal and external factors affecting transition planning;
3. Discussion with DHHS staff on the process for developing individual budgets for individuals with complex medical conditions transitioning to an integrated community setting. Such individualized budgets are the method by which the State commits state funds up to $100,000 to facilitate and support transition to programs such as the Palm Street residence;
4. Review of information submitted by DHHS in response to questions regarding:
    a. Current application of funds for integrated community settings/placements for Glencliff residents with complex health care needs;
    b. Process for stimulating and supporting the creation of additional housing and residential resources such as the Palm Street residence;
    c. Process for promoting and accelerating applications for the various Medicaid waivers. Acceptance into one of the waivers often seems to be a precondition for transition from Glencliff; and
    d. Process for working with State officials and designated community providers (such as CMHCs and Area Agencies) to promote and facilitate access to community providers who can serve people transitioning from Glencliff under one of the Medicaid waivers; and
5. Telephone conference with DHHS officials to discuss the information submitted.

Based on the above information, the ER prepared a draft report for consideration by both the State and representatives of the plaintiffs.

The following is a very brief summary of ER recommendations for (State/DHHS led) actions and interventions:

1. *Substantially improve in-reach from the community to Glencliff.*
2. *Improve the success and timeliness of access to Medicaid waivers in support of transitions to integrated community settings.*
3. *Have DHHS Bureau of Mental Health Services (BMHS) staff work more closely and pro-actively with other DHHS officials and the Area Agencies to increase access to community providers.*
4. *Improve access to Bridge subsidies to facilitate transitions from Glencliff.*
5. *Expand access to small scale (3 - 4 person) community residential programs for Glencliff residents with complex medical conditions.*
6. *Make it a very high priority to develop new small scale residential settings for residents with complex medical conditions as soon as possible. This appears to be the most feasible approach to re-starting movement of people to integrated community settings. Some individuals have been waiting for transition for a long time. Others will be encouraged to choose community living by seeing the success and satisfaction of residents that have moved to these programs.*

All parties have now reviewed that draft report; the State reports that it is beginning to address some of its recommendations. In addition, representatives of the Plaintiffs provided a tele-conference training session on informed consent and person-centered transition planning. In addition, the State has shared applicable case records with representatives of the Plaintiffs so that they can be better informed about specific issues related to transition planning for Glencliff residents.

The State has executed a contract with Northern Human Services to provide in-reach services for residents of Glencliff, and the in-reach coordinator has been hired. As of the date of this report, implementation of the in-reach functions and activities is at a very early stage. Implementation has been hindered by the COVID-19 restrictions that have been in effect in New Hampshire since March, 2020. In addition, the State has not yet shared with the ER or representatives of the Plaintiffs the data reporting format to be used to track and report on the activities and results of the in-reach program. It is too early to document whether the in-reach program is having the desired effect for Glencliff residents.

The ER intends to closely monitor activities related to Glencliff transition planning over the next six month period. This monitoring of in-reach programming will focus on:

1. Implementation of the in-reach program, including written transition plans, community visits, re-starting the HOPES program, etc.;

2. Reviewing, in concert with representatives of the Plaintiffs, all revisions to policies, procedures, forms, training contents, etc. related to transition planning and informed consent;
3. Tracking and analyzing data reported by the in-reach program to the State;
4. Assessing the degree to which all CMHCs in the state become re-engaged in transition planning and in developing integrated community settings for Glencliff residents;
5. Tracking progress of the 28 individuals on the active discharge planning list towards integration into the community;
6. Documenting the development of new integrated community settings for Glencliff residents.

The ER recommends that the parties reconvene in the early fall of 2020 to examine preliminary data on the delivery of in-reach services, review the State's proposed revisions to the transition planning and informed choice process, and discuss efforts to expand community residential service options for Glencliff residents, including access to medical model homes, Enhanced Family Care and Bridge subsidies.

The ER recognizes that the State intends to improve transition planning and to facilitate additional community integrated transitions for Glencliff residents. **However, at this point, and based on the review conducted in January, the State is not in compliance with CMHA provisions related to Glencliff transition planning or transitions to integrated community settings.**

Preadmission Screening and Resident Review (PASRR)

The State periodically provides data on PASRR Level II screens conducted in New Hampshire. Recent PASRR data are summarized in Table XVIII below. PASRR data from two previous reporting periods are included for comparison purposes.

A Level II screen is conducted if a PASRR Level I (initial) screen identifies the presence of mental illness, intellectual disability, or related conditions for which a nursing facility placement might not be appropriate. One objective of the Level II screening process is to seek alternatives to nursing facility care by diverting people to appropriate integrated community settings. Another objective is to identify the need for specialized facility-based services if individuals are deemed to need nursing facility level of care.

Table XVIII

Self-Reported PASRR Level II Screens

	October 2019 through June 2020	**October 2019 through June 2020 Percent**	**April through June 2019 Percent**	**July through September 2019 Percent**
Full Approval - No Specialized Services	25	37.9%	28.8%	31.0%
Full Approval with Specialized Services	20	30.3	28.8	38.0
Provisional – No Specialized Services	11	16.7	18.8	19.7
Provisional with Specialized Services	10	15.2	23.8	11.3
Total	66%	100%	100%	100%

In the December 2018 ER report, 10.2% of the Level II screens were approved with a specification for specialized services. At that time, the ER questioned whether this was an unusually low rate for specification of specialized services. In a comparison with one other state, the ER found substantially higher approvals for specialized services than was evidenced in New Hampshire at that time. In the intervening period, the State and the PASRR contractor have been reviewing protocols for specification of specialized services in the Level II process. For this current report, the percentage of approvals with specialized services has increased to 45.1%. For the period April through June 2019, the percent of total Level II screens indicating specialized services was 44%; for July through September 2019, the number was 49.3%.

In addition, the State expressed its intent to review the New Hampshire Medicaid Plan to see if revisions may be appropriate for the section(s) of that Plan identifying what special services may be covered by Medicaid for recipients for whom the Level II screen results in a specification for special services. The State reports that it has not yet completed this review. The ER expects that the review and any changes to the Medicaid Plan with respect to special services will be completed no later than October 1, 2020.

For a variety of reasons, virtually all PASRR screens in New Hampshire are conducted for people who are already in a nursing facility. For example, for October 2019 through March 2020, 96.7% of Level II screens were conducted in nursing facilities. A possible consequence of this is that prime opportunities for diversion to integrated community settings may have already been missed by the time the PASRR screen is conducted.

In addition, individuals admitted to Glencliff must typically have been turned down by at least two other facilities before being considered for admission. In combination, these facts indicate that interventions to divert individuals from Glencliff or other nursing facilities must typically be used before the PASRR screening process is initiated. PASRR is important to assure that people with mental illness, ID/DD, or related conditions are not inappropriately institutionalized or placed in nursing facilities without access to necessary special services. However, PASRR is not by itself sufficient to divert people from nursing facility care. Up-stream interventions at NHH, the DRFs, and among the CMHCs are also essential to prevent unnecessary facility placement.

New Hampshire Hospital and the Designated Receiving Facilities (DRFs)

For the time period October 2019 through March 2020, the State reports that NHH effectuated 453 admissions and 452 discharges. The mean daily census was 159.5, and the median length of stay for discharges was 16 days.

Table XIX below compares NHH discharge destination information for the six most recent reporting periods. The numbers are expressed as percentages because the length of the reporting periods had not previously been consistent, although the type of discharge destination data reported has been consistent throughout.

Table XIX

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	**Percent October 2017 through March 2018**	**Percent April 2018 through Septem-ber 2018**	**Percent October 2018 through March 2019**	**Percent July through Septem-ber 2019**	**Percent October through Decem-ber 2019**	**Percent January through March 2020**
Home – live alone or with others	81.0%	81.7%	73.26%	70.5%	70.76%	72.77%
Glencliff	1.0%	1.45%	1.6%	0.4%	0.42%	2.35%
Homeless Shelter/motel	2.5%	3.13%	6.68%	4.38%	7.11%	5.16%
Group home 5+/DDS supported living, peer support housing etc.	7.1%	4.1%	4.01%	3.98%	4.24%	3.29%
Jail/correction	2%	1.45%	2.94%	1.2%	3.0%	1.41%
Nursing home/rehab facility	2.7%	5.3%	4.55%	5.98%	5.00%	4.69%
Other[14]					10.17%	10.33%

[14] The ER did not include the "Other" category in previous reports.

The State now consistently reports information on the hospital-based Designated Receiving Facilities (DRFs) and the Cypress Center in New Hampshire. It is important to capture the DRF/Cypress Center data and analyze it with NHH and Glencliff data to get a total institutional census across the state for the SMI population. Table XX summarizes these data.

Table XX

Self-Reported DRF/APRTP Utilization Data: January 2016 through March 2020

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Admissions						
Jan - March 2016	69	257	NA	65	121	512
April - June 2016	79	205	378	49	92	803
July - Sept 2016	37	207	375	54	114	787
April - June 2017	60	228	363	52	101	804
July - September 2017	NA**	247	363	60	121	722
Oct. - Dec 2017	59	209	358	55	102	783
Jan. - March 2018	52	240	330	66	100	788
April - June, 2018	69	244	333	65	104	815
July - September 2018	67	201	357	54	112	791
October - December 2018	87	198	375	64	72	796
January - March 2019	126	182	349	56	123	836
April to June 2019	108	187	371	89	108	865
July to September 2019	104	194	391	52	95	836
October - December 2019	96	175	350	63	100	784
January - March 2020	114	186	333	52	107	794

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Percent involuntary						
Jan - March 2016	53.60%	18.70%	NA	18.50%	30.60%	NA
April - June 2016	55.70%	24.40%	16.93%	4.10%	48.90%	25.50%
July - Sept 2016	43.20%	29.50%	18.90%	13.00%	44.70%	26.20%
April - June 2017	58.30%	21.50%	22.00%	1.00%	47.50%	27.10%
July - September 2017	NA**	37.1%	25.60%	10.00%	50.40%	NA
Oct. - Dec 2017	49.20%	30.10%	23.70%	12.70%	50.00%	30.00%
Jan. - March 2018	44.20%	28.30%	21.50%	6.10%	47.00%	27.00%
April - June, 2018	46.73%	25.82%	24.62%	9.23%	51.92%	29.08%
July - September 2018	28.36%	24.38%	19.33%	12.96%	49.11%	25.16%
October - December 2018	46.00%	23.20%	22.40%	6.25%	51.40%	26.50%
January - March 2019	45.20%	18.10%	23.20%	12.50%	47.20%	28.20%
April to June 2019	61.10%	20.90%	19.40%	7.90%	47.20%	27.30%
July to September 2019	43.30%	16.50%	25.10%	11.50%	55.80%	28.00%
October - December 2019	63.50%	23.40%	24.00%	7.90%	40.00%	29.50%
January - March 2020	53.50%	24.20%	21.00%	9.60%	40.00%	28.09%

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Mean Daily Census						
Jan - March 2016	7.9	14.7	NA	19.7	18.1	NA
April - June 2016	7.8	13.2	21.4	22.5	16.9	81.8
July - Sept 2016	4.5	13.6	23.2	25.6	14.5	81.4
April - June 2017	4.5	12	30.3	29.3	10	86.1
July - September 2017	NA**	12.9	23.9	29.7	12.2	NA
Oct. - Dec 2017	10.1	12.3	27.7	32.6	16.1	19.7
Jan. - March 2018	6.7	11.6	32.5	34.6	NA	NA
April - June, 2018	9.1	11.9	31.7	31.7	20.4	104.8
July - September 2018	11.8	8.4	39.6	33.8	18.2	111.8
October - December 2018	10.7	9.2	27.4	33.4	10.7	91.4
January - March 2019	8.5	14.5	30.4	22.6	14.9	90.9
April to June 2019	8.4	11.5	29.7	27	12.1	88.7
July to September 2019	9.4	12.2	24.1	24.1	12	81.8
October - December 2019	10.6	13.4	31.8	23.7	9.5	89
January - March 2020	10.6	13.7	29.2	20.5	12	86

Discharges	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Jan - March 2016	77	231	345	69	120	842
April - June 2016	78	206	363	51	90	788
July - Sept 2016	35	213	380	64	113	805
April - June 2017	59	232	365	54	105	815
July - Sep 2017	NA**	243	355	63	121	NA
Oct - Dec 2017	82	212	359	58	102	813
Jan - March 2018	53	248	326	67	101	795
April - June 2018	74	244	326	65	107	816
Oct - Dec 2018	89	204	358	62	79	792
Jan - March 2019	124	177	348	56	106	811
April - June 2019	108	193	368	55	111	835
July - Sep 2019	101	192	386	54	97	830
Oct - Dec 2019	102	198	353	60	123	836
Jan - March 2020	110	207	327	71	119	834

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Mean LOS for Discharges						
Jan - March 2016	6	4	5	18	7	6
April - June 2016	6	4	4	28	7	6
July - Sept 2016	7	5	4	24	8	7
April - June 2017	6	4	5	22	8	6
July - Sept 2017	NA	4	4	27	7	NA
Oct - Dec 2017	4	4	5	21	7	5
Jan - March 2018	5	4	5	23	7	5
April - June 2018	5	4	5	20	8	5
Oct - Dec 2018	4	3	4	31	7	4
Jan - March 2019	5	5	6	18	9	6
April - June 2019	5	3	5	18	7	5
July - Sept 2019	6	4	6	26	8	6
Oct - Dec 2010	7	5	6	25	7	7
Jan - March 2020	6	5	6	20	8	6

The DRFs should theoretically relieve some of the pressure on NHH for inpatient admissions, and should also reduce the number of people waiting for psychiatric admissions in hospital EDs.

DHHS has recently begun tracking discharge dispositions for people admitted to the DRFs and Cypress Center. Table XXI below provides a summary of these recently reported data.

Table XXI

Self-Reported Discharge Dispositions for DRFs in New Hampshire

October 2019 through March 2020

Disposition	Frank-lin	Cy-press	Ports-mouth	Elliot Geriatric	Elliot Pathways	Total	Per-cent
Home	199	382	489	29	209	1,308	78.3%
NHH	6	0	6	0	0	12	0.72%
Residential Facility/ Assisted Living	0	0	0	36	0	36	2.16%
Other DRF[15]	0	13	5	1	5	24	1.44%
Hospital	0	0	0	0	0	0	0.00%
Death	0	0	0	0	0	0	0.00%
Other or Unknown	7	10	180*	65	28	290	17.4%
Total	212	405	680	131	242	1,670	

*The Other or Unknown disposition category for Portsmouth Regional is reported to include shelters, rehab facilities, hotels/motels, friends/families, and unknown[16].

Based on these self-reported data, 78.3% of discharges from DRFs and the Cypress Center are to home. This is essentially the same as the 72.77% discharges to home reported by NHH.

Hospital Readmissions

DHHS is now reporting readmission rates for both NHH and the DRFs. Table XXII below summarizes these data:

[15] The State reports that these transfers reflect conversion from involuntary to voluntary status, not transfers among DRF facilities.

[16] The ER intends to ask the State for a more definitive breakdown of these data. In particular, the ER is concerned about discharges to shelters and to hotels/motels.

Table XXII

Self-Reported Readmission Rates for NHH and the DRFs

July 2017 through March 2020

	Percent 30 Days	Percent 90 Days	Percent 180 Days
NHH			
7 to 9/2017	9.80%	21.60%	27.90%
10 to 12/2017	12.8%	26.1%	32.8%
1 to 3/2018	13.7%	22.7%	29.9%
4/2018 to 6/2018	7.6%	14.7%	23.4%
7/2018 to 9/2018	8.6%	19.6%	25.4%
10/2018 to 12/2018	7.3%	18.1%	25.9%
1/2019 to 3/2019	5.3%	14.8%	21.2%
4/2109 to 6/2019	8.4%	15.0%	20.3%
7/2019 to 9/2019	10.5%	18.6%	23.3%
10/2019 to 12/2019	6.8%	17.9%	23.0%
1/2020 to 3/2020	6.9%	12.4%	21.1%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Franklin			
7 to 9/2017	NA	NA	NA
10 to 12/2017	10.2%	10.2%	10.2%
1 to 3/2018	0.0%	0.0%	1.9%
4/2018 to 6/2018	4.3%	5.8%	5.8%
7/2018 to 9/2018	6.0%	9.0%	16.4%
10/2018 to 12/2018	2.3%	4.6%	5.7%
1/2019 to 3/2019	7.9%	10.3%	10.3%
4/2109 to 6/2019	6.5%	9.3%	12.0%
7/2019 to 9/2019	1.9%	6.7%	9.6%
10/2019 to 12/2019	3.1%	6.2%	9.3%
1/2020 to 3/2020	3.5%	6.1%	7.8%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Cypress			
7 to 9/2017	7.10%	12.40%	15.90%
10 to 12/2017	12.00%	18.70%	24.40%
1 to 3/2018	4.20%	9.60%	15.80%
4/2018 to 6/2018	4.50%	8.20%	11.90%
7/2018 to 9/2018	8.50%	13.90%	18.90%
10/2018 to 12/2018	7.10%	11.10%	15.20%
1/2019 to 3/2019	5.50%	14.80%	17.60%
4/2109 to 6/2019	9.90%	15.10%	20.80%
7/2019 to 9/2019	6.60%	9.20%	12.80%
10/2019 to 12/2019	10.30%	13.90%	21.10%
1/2020 to 3/2020	3.50%	5.00%	8.50%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Portsmouth			
7 to 9/2017	11.50%	17.50%	21.00%
10 to 12/2017	8.70%	13.70%	17.60%
1 to 3/2018	8.80%	15.50%	20.60%
4/2018 to 6/2018	10.20%	15.90%	21.90%
7/2018 to 9/2018	8.40%	12.90%	19.00%
10/2018 to 12/2018	7.70%	14.90%	20.30%
1/2019 to 3/2019	12.90%	19.50%	23.50%
4/2109 to 6/2019	10.50%	17.80%	22.40%
7/2019 to 9/2019	8.20%	12.00%	12.00%
10/2019 to 12/2019	7.50%	8.80%	15.30%
1/2020 to 3/2020	9.70%	19.20%	23.00%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Elliot Pathways			
7 to 9/2017	3.30%	6.60%	12.40%
10 to 12/2017	5.80%	7.70%	12.50%
1 to 3/2018	NA	NA	NA
4/2018 to 6/2018	3.80%	6.70%	8.60%
7/2018 to 9/2018	9.00%	3.60%	3.60%
10/2018 to 12/2018	2.80%	5.60%	9.70%
1/2019 to 3/2019	4.90%	5.70%	7.30%
4/2109 to 6/2019	5.50%	5.50%	5.50%
7/2019 to 9/2019	2.10%	5.20%	6.30%
10/2019 to 12/2019	3.90%	5.80%	8.70%
1/2020 to 3/2020	9.70%	14.20%	15.90%

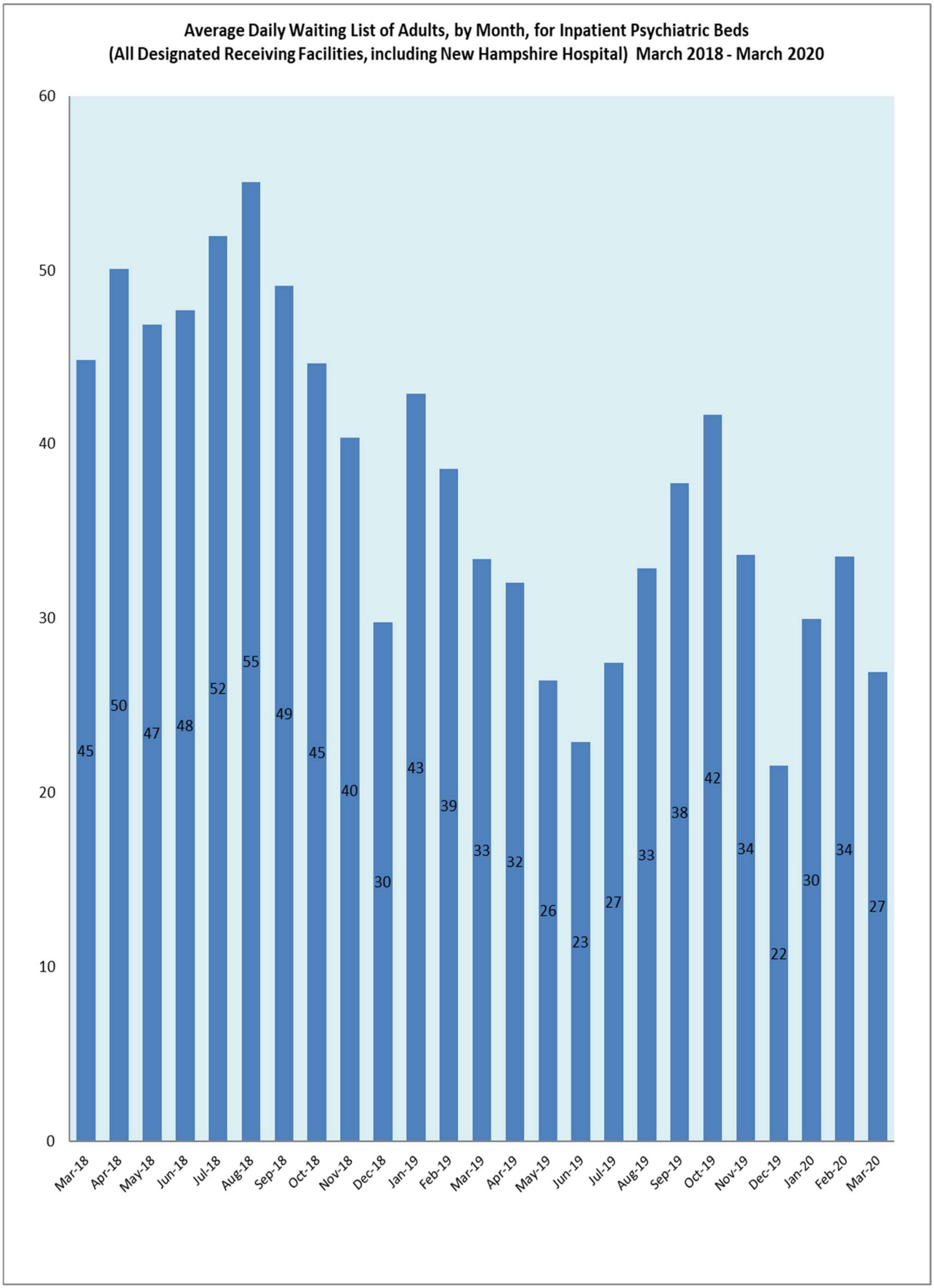
	Percent 30 Days	Percent 90 Days	Percent 180 Days
Elliott Geriatric			
4/2018 to 6/2018	6.10%	6.10%	6.10%
7/2018 to 9/2018	5.60%	11.10%	11.10%
10/2018 to 12/2018	6.30%	7.80%	9.40%
1/2019 to 3/2019	5.40%	5.40%	5.40%
4/2109 to 6/2019	10.10%	12.40%	14.60%
7/2019 to 9/2019	7.70%	9.60%	13.50%
10/2019 to 12/2019	5.70%	7.10%	8.60%
1/2020 to 3/2020	9.40%	11.30%	18.90%

For the 36-month period in which re-admission rate data has been reported, the rates of readmission have trended down somewhat for all but three DRFs, which is a positive indicator overall. However, readmission rates, especially the 180-day readmission rate for NHH and Portsmouth, are high. At least 21.1% of all people discharged from NHH are back in the hospital within 180 days. These data, in concert with the hospital emergency department data presented below, indicate that gaps remain in community services for people with serious mental illness, and that the essential connection between inpatient care and community services is not being effectuated for sizeable numbers of people at risk of re-hospitalization. **These facts need to be understood in light of the State's ongoing efforts to increase ACT capacity and enrollment as documented earlier in this report. There needs to be increased focus on**

whether or not those readmitted to NHH or a DRF are being screened, assessed, and linked (when appropriate) to ACT and supported housing upon discharge.

Hospital ED Waiting List

In the previous three reports, the ER has identified the hospital ED boarding wait for admission to NHH to be an important indicator of overall system performance. The following two charts display adult admissions delays to NHH bi-weekly for the period April 2018 through March 2020.


Average Daily Waiting List of Adults, by Month, for Inpatient Psychiatric Beds
(All Designated Receiving Facilities, including New Hampshire Hospital) March 2018 - March 2020
60
50
40
30
20
10
0
45
50
47
48
52
55
49
45
40
30
43
39
33
32
26
23
27
33
38
42
34
22
30
34
27
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
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Oct-19
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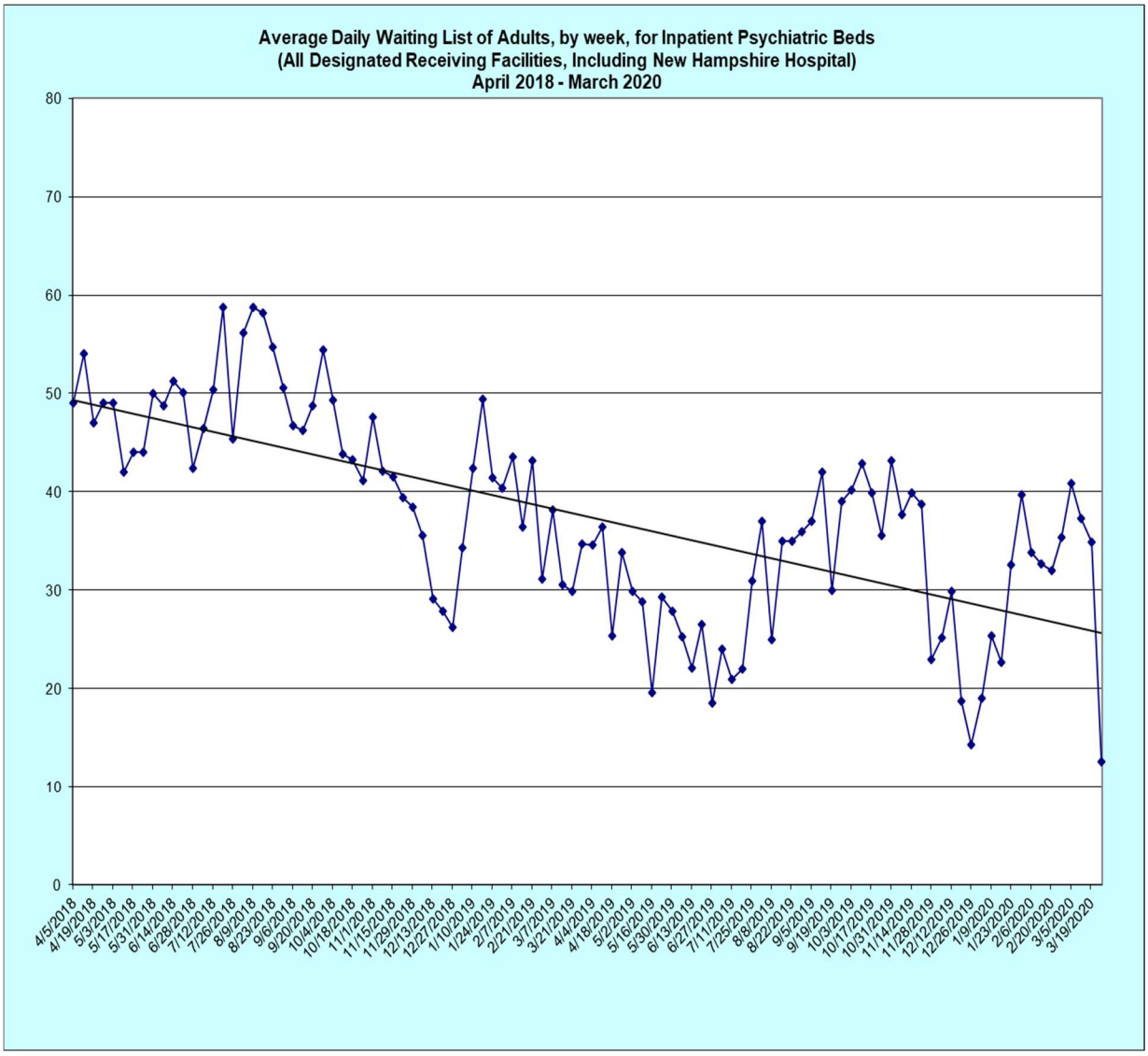
Dec-19
Jan-20
Feb-20
Mar-20



The overall trend has been downward since September 2018. The ER notes that many of the interventions implemented by the State are outside the direct scope of the CMHA. However, ED boarding can affect the CMHA target population in a variety of ways. And, people awaiting psychiatric hospital admission are potential participants in ACT, MCT, crisis apartments, and other CMHA services. Thus, the ER intends to continue on reporting ED boarding in future reports.

Family and Peer Supports

Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services. The ER will arrange for additional NAMI meetings during the next six months.

Peer Support Agencies

DHHS continues to report having a total of 15 peer support agency program (PSA) sites, with at least one program site in each of the ten regions. The State continues to report that all peer support centers meet the CMHA requirement to be open 44 hours per week. As of March 2020, the State reports that those sites have a cumulative total of 1,558 members, with an active daily participation rate of 170 people statewide. This represents a three-year high in active daily participation: 23% higher than in March 2017. The State reports that all of the PSAs have been working to increase their membership and daily participation rates.

The ER intends to complete a set of PSA on-site visits within the next year (by June 30, 2021). Until those visits are complete, there will be no further information to report about these programs.

IV. Quality Assurance Systems

The state-wide limitations implemented to minimize spread of COVID-19 have prevented the State from conducting QSR or Fidelity reviews since March 2020. This means that there are only a few QSR and Fidelity reports for the time period covered by this report. In addition, the lack of QSR and Fidelity reports for this time period makes it impossible to tabulate either cumulative or time-series data related to the QSR and Fidelity activities. For this reason, a discussion of Quality and Fidelity is not included in this report.

The State reports that QSR on-site reviews were re-started in June, 2020. The ER intends to observe several of these activities prior to completing the December 2020 report.

I. Summary of Expert Reviewer Observations and Priorities

The ER has emphasized in this report that the State continues to be far from compliant with CMHA requirements for ACT. **For the last three and one half years the ER has reported that the State is out of compliance with the ACT requirements of Sections V.D.3, which together require that the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the target population at any given time.**

Other areas of non-compliance identified in this report include:

1. **Pending further review and verification of State-reported information, the ER is not able at this time to document that the CMHA-required capacity of 600 supported housing units is currently available to the CMHA target population. In addition, approved applicants continue to remain on the wait list for excessive periods of time, in violation of the CMHA;**
2. **With regard to Glencliff, the ER has documented failure to provide effective transition planning and in-reach activities, failure to transition residents of Glencliff into integrated community settings in accordance with the CMHA, and failure to expand community residential and other service capacity to meet the needs of Glencliff residents in alternative community settings. In addition, the ER cannot document or certify that residents of Glencliff have written transition plans in accordance with CMHA requirements; and**
3. **Although the State technically meets the statewide CMHA standard for SE penetration, the ER notes seven of the ten CMHC regions of the state have penetration rates lower than the standard. At the very least, the ER considers that this demonstrates that target population members do not have equal access to SE services throughout New Hampshire.**

More than five years ago, all parties to the CMHA envisioned implementation of a number of remedial services and system interventions designed to assure positive outcomes for the defined target population. Most important among these outcomes was assurance of maximum community integration supported by housing and evidence-based and high quality services meeting individual needs and choices. The signatories to the CMHA envisioned high quality of life and improved personal outcomes for adult citizens of New Hampshire with serious mental illness.

Now, more than five years later, the data and related information reported by the State and the ER show: (1) declining ACT enrollments; (2) declining SE penetration in many regions of the State; (3) declining utilization of Bridge Program SH subsidies; and (4) continued delays in effectuating access to integrated community living options for Glencliff residents. In light of these facts, the ER must report that in certain ways the CMHA target population is less well-served in this time period than it had been in previous periods. In these areas, the State appears to be falling further from compliance with the CMHA rather than attaining greater compliance. **As the ER has stated in previous reports, the State will not be able to disengage from the CMHA until full compliance is reached for all requirements of the CMHA.**

In furtherance of this goal, the ER expects the State to develop and implement measures to address all areas of non-compliance referenced above, with the following actions to take place between now and October 15, 2020:

1) The State will provide a written update on implementation of specific ACT strategies identified in the working group memo, with emphasis on eliminating the wait list and on reducing the elapsed time for CMHAs to process individuals into ACT services.

2) The State will facilitate an all-parties review of responses to the MCT/CA RFI and will engage in discussions with the parties about how this information impacts current and future MCT/CA procurements and oversight and operations. These discussions should include the situation arising from Harbor Homes' decision not to renew its MCT contract, and how the provision of MCT in the greater Nashua area will be addressed.

3) The State will draft new policies and procedures related to informed choice and transition planning for residents of Glencliff, and will engage the parties in review and comment on these before they are implemented (Note: a call to initiate review of these policies and procedures has been scheduled.) In addition, the State will take effective steps to ensure that the CMHCs, with the assistance of the Northern in-reach liaison, become more active in the transition planning process at every stage, especially with regard to the 49 individuals included in the ER's Glencliff site review and report.

4) The State will develop a plan to expand access to other community residences, like Palm Street, or existing community programs, like extended family care homes or supported housing, for Glencliff residents with complex health conditions.

5) The State will provide all parties with a telephone briefing on the SH program, including an estimate of the total number of SH units that can be placed under lease and occupied in the next twelve months; clarification of the number of new 811 program occupants who have transitioned from the Bridge program as opposed to from other living arrangements; and specific strategies that have been implemented to assist individuals on the waiting list move to SH.

6) An All Parties meeting will be held to discuss progress and strategies related to disengagement from the CMHA.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

January through March, 2020

New Hampshire Community Mental Health Agreement Quarterly Data Report

January – March 2020

New Hampshire Department of Health and Human Services

Bureau of Quality Assurance and Improvement

June 8, 2020

Community Mental Health Agreement Quarterly Data Report

New Hampshire Department of Health and Human Services

Publication Date: June 8, 2020

Reporting Period: 1/1/2020 – 3/31/2020

Notes for Quarter

- On March 13, 2020, Governor Christopher T. Sununu issued Executive Order 2020-04, declaring a State of Emergency due to the Novel Coronavirus (COVID-19). On March 26, 2020, Governor Sununu issued related Emergency Order #17, implementing a stay-at-home, shelter in place of residence requirement, effective March 27, 2020 at 11:59 PM. This report includes data regarding service provision prior to and during the effective dates of these orders, which remained in place for the balance of the reporting period.
- Table 3d. Community Mental Health Center Services: Supported Employment Waiting List is newly added to this report.

Acronyms Used in this Report

ACT:	Assertive Community Treatment
BMHS:	Bureau of Mental Health Services
BQAI:	Bureau of Quality Assurance and Improvement
CMHA:	Community Mental Health Agreement
CMHC:	Community Mental Health Center
DHHS:	Department of Health and Human Services
DRF:	Designated Receiving Facility
ED:	Emergency Department
FTE:	Full Time Equivalent
HBSP:	Housing Bridge Subsidy Program
HUD:	US Department of Housing and Urban Development
MCT:	Mobile Crisis Team
NHH:	New Hampshire Hospital
NHHFA:	New Hampshire Housing Finance Authority
PRA:	Project Rental Assistance
SE:	Supported Employment

SFY: State Fiscal Year

VA: Veterans Benefits Administration

1a. Community Mental Health Center Services: Unique Count of Adult Assertive Community Treatment Clients

Community Mental Health Center	January 2020	February 2020	March 2020	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	115	114	115	126	131
02 West Central Behavioral Health	44	45	42	47	52
03 Lakes Region Mental Health Center	57	56	57	60	62
04 Riverbend Community Mental Health Center	97	89	94	107	107
05 Monadnock Family Services	51	51	51	52	51
06 Greater Nashua Mental Health	99	103	101	106	105
07 Mental Health Center of Greater Manchester	278	270	262	294	312
08 Seacoast Mental Health Center	66	66	66	68	73
09 Community Partners	75	67	68	77	75
10 Center for Life Management	48	46	47	49	52
Total Unique Clients	**929**	**907**	**903**	**985**	**1,017**
Unique Clients Receiving ACT Services 4/1/2019 to 3/31/2020:			**1,225**		

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 4/21/2020; clients are counted only one time regardless of how many services they receive.

1b. Community Mental Health Center Services: Assertive Community Treatment Screening and Resultant New ACT Clients

Community Mental Health	October – December 2019	July – September 2019

Center	Retrospective Analysis			Retrospective Analysis		
	Unique Clients Screened: Individuals Not Already on ACT*	Appropriate for Further ACT Assessment: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening	Unique Clients Screened: Individuals Not Already on ACT*	Appropriate for Further ACT Assessment: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening
01 Northern Human Services	1,166	21	2	1,163	40	4
02 West Central Behavioral Health	221	2	2	250	1	0
03 Lakes Region Mental Health Center	906	11	1	866	6	0
04 Riverbend Community Mental Health Center	1,342	13	2	1,083	0	0
05 Monadnock Family Services	576	3	0	576	6	0
06 Greater Nashua Mental Health	726	6	1	708	8	5
07 Mental Health Center of Greater Manchester	1,641	7	1	1,632	1	0
08 Seacoast Mental Health Center	1,392	48	0	1,257	31	0
09 Community Partners	434	0	0	360	3	0
10 Center for Life Management	779	2	0	763	1	0
Total ACT Screening	**9,183**	**113**	**9**	**8,658**	**97**	**9**

Data Source: NH Phoenix 2 and CMHC self-reported ACT screening records. ACT screenings submitted through Phoenix capture ACT screenings provided to clients found eligible for state mental health services. Phoenix does not capture data for non-eligible clients; three CMHCs

submit this data through Phoenix. Seven CMHCs self-report. All such screenings, excluding individuals who are already on ACT, are contained in this table.

Notes: Data extracted 4/28/2020. "Unique Clients Screened: Individuals Not Already on ACT" is defined as individuals who were not already on ACT at the time of screening that had a documented ACT screening during the identified reporting period. "Screening Deemed Appropriate for Further ACT Assessment: Individuals Not Already on ACT" is defined as screened individuals not already on ACT that resulted in referral for an ACT assessment. "New Clients Receiving ACT Services within 90 days of ACT Screening" is defined as individuals who were not already on ACT that received an ACT screening in the preceding quarter and then began receiving ACT services.

1c. Community Mental Health Center Services: New Assertive Community Treatment Clients

Community Mental Health Center	January – March 2020				October -- December 2019			
	New ACT Clients	2019 New ACT Clients	New ACT Clients	Total New ACT Clients	New ACT Clients	2019 New ACT Clients	2019 New ACT Clients	Total New ACT Clients
01 Northern Human Services	2	4	4	**10**	1	2	3	**6**
02 West Central Behavioral Health	3	2	1	**6**	4	1	6	**11**
03 Lakes Region Mental Health Center	1	1	2	**4**	0	0	5	**5**
04 Riverbend Community Mental Health Center	8	4	1	**13**	6	7	7	**20**
05 Monadnock Family Services	0	0	1	**1**	0	1	0	**1**
06 Greater Nashua Mental Health	3	5	0	**8**	4	2	0	**6**
07 Mental Health Center of Greater Manchester	8	7	4	**19**	10	3	4	**17**
08 Seacoast Mental Health Center	2	2	0	**4**	2	1	0	**3**
09 Community Partners	2	1	1	**4**	1	2	2	**5**
10 Center for Life Management	0	1	0	**1**	2	1	0	**3**

Total New ACT Clients	**29**	**27**	**14**	**70**	**30**	**20**	**27**	**77**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 4/21/2020; New ACT Clients are defined as individuals who were not already on ACT within 90 days prior who then began receiving ACT services. This information is not limited to the individuals that received an ACT screening within the previous 90-day period, and may include individuals transitioning from a higher or lower level of care into ACT.

1d. Community Mental Health Center Services: Assertive Community Treatment Waiting List

As of 3/31/2020						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180+* days**
10	0	3	4	1	0	2
As of 12/31/2019						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
5	2	0	2	1	0	0

Revisions to Prior Period: None.

Data Source: BMHS Report.

*Notes: Data compiled 04/20/2020. *1 case at 154 days and 1 at 197 days. All 10 cases are at MHCGM; increased services are being provided by existing treatment team until assigned to ACT team.*

1e. Community Mental Health Center Services: Assertive Community Treatment – New Hampshire Hospital Admission and Discharge Data Relative to ACT

	January - March 2020						October – December 2019					
	On ACT at Admission		d for ACT on Dischar		d to ACT at Dischar		On ACT at Admission		d for ACT on Dischar		d to ACT at Dischar	
Community Mental Health Center	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
01 Northern Human Services	5	11	0	11	0	0	4	8	1	7	1	0
02 West Central Behavioral Health	4	8	3	5	1	2	3	5	1	4	1	0
03 Lakes Region Mental Health Center	3	3	1	2	0	1	5	10	2	8	1	1
04 Riverbend Community Mental Health	11	18	5	13	3	2	8	20	5	15	4	1

Center												
05 Monadnock Family Services	6	4	1	3	1	0	3	8	2	6	0	2
06 Greater Nashua Mental Health	12	18	10	8	5	5	9	14	3	11	1	2
07 Mental Health Center of Greater Manchester	8	14	2	12	0	2	13	11	3	8	3	0
08 Seacoast Mental Health Center	0	6	2	4	0	2	7	8	3	5	0	3
09 Community Partners	1	12	4	8	1	3	6	14	1	13	0	1
10 Center for Life Management	3	4	0	4	0	0	6	6	4	2	3	1
Total	**53**	**98**	**28**	**70**	**11**	**17**	**64**	**104**	**25**	**79**	**14**	**11**

Revisions to Prior Period: None

Data Source: New Hampshire Hospital.

Notes: Data compiled 04/20/20.

1f. Community Mental Health Center Services: Assertive Community Treatment – Reasons Not Accepted to ACT at New Hampshire Hospital Discharge Referral

Reason Not Accepted at Discharge	January - March 2020	October - December 2019
Not Available in Individual's Town of Residence	0	0
Individual Declined	0	1
Individual's Insurance Does Not Cover ACT Services	0	0
Individual's Clinical Need Does Not Meet ACT Criteria	1	2
Individual Placed on ACT Waitlist	1	0
Individual Awaiting CMHC Determination for ACT	15	8
Total Unique Clients	**17**	**11**

Revisions to Prior Period: None.

Data Source: New Hampshire Hospital.

Notes: Data compiled 04/20/2020.

2a. Community Mental Health Center Services: Assertive Community Treatment Staffing Full Time Equivalents

Community Mental Health Center	March 2020						December 2019	
	Nurse	Clinician/or Equivalent	Support Worker	Peer Specialist	(Excluding Psychiatry)	rse Practitioner	(Excluding Psychiatry)	Psychiatrist/Nurse Practitioner
01 Northern Human Services	1.81	1.80	12.25	0.51	16.37	1.20	16.97	1.20

02 West Central Behavioral Health	0.70	1.20	3.70	0.50	6.10	0.50	8.75	0.50
03 Lakes Region Mental Health Center	1.00	2.00	3.00	1.00	7.00	0.75	7.00	0.75
04 Riverbend Community Mental Health Center	0.50	2.00	8.00	0.00	10.50	0.50	11.50	0.50
05 Monadnock Family Services	2.00	2.25	3.50	1.10	8.85	0.65	8.75	0.65
06 Greater Nashua Mental Health 1	0.50	1.00	4.00	1.00	6.50	0.25	8.00	0.25
06 Greater Nashua Mental Health 2	0.50	1.00	5.00	1.00	7.50	0.25	8.00	0.25
07 Mental Health Center of Greater Manchester-CTT	1.00	11.00	5.25	1.00	18.25	0.91	15.75	0.91
07 Mental Health Center of Greater Manchester-MCST	1.00	7.00	7.25	1.00	16.25	0.91	15.75	0.91
08 Seacoast Mental Health Center	1.00	2.10	5.00	1.00	9.10	0.60	10.10	0.60
09 Community Partners	0.50	3.00	7.55	0.00	11.05	0.63	10.80	0.63
10 Center for Life Management	1.25	2.00	4.30	1.00	8.55	0.40	9.55	0.40
Total	**11.76**	**36.35**	**69.80**	**9.11**	**127.02**	**7.55**	**130.92**	**7.55**

2b. Community Mental Health Center Services: Assertive Community Treatment Staffing Competencies

Community Mental Health Center	Substance Use Disorder Treatment		Housing Assistance		Supported Employment	
	March 2020	December 2019	January 2020	December 2019	January 2020	December 2019
01 Northern Human Services	2.55	3.15	10.75	10.75	1.50	1.50
02 West Central Behavioral Health	0.20	0.40	4.10	6.50	0.60	1.40
03 Lakes Region Mental Health Center	1.00	1.00	6.00	6.00	2.00	3.00
04 Riverbend Community Mental Health Center	1.50	1.50	9.50	9.50	0.50	0.50
05 Monadnock Family Services	1.40	1.40	2.00	2.00	1.00	1.00
06 Greater Nashua Mental Health 1	4.25	5.25	6.25	6.25	1.00	1.50
06 Greater Nashua Mental Health 2	5.25	5.25	7.00	5.00	0.00	0.50
07 Mental Health Center of Greater Manchester-CCT	10.91	9.91	13.75	11.75	2.00	1.50
07 Mental Health Center of Greater Manchester-MCST	5.91	5.91	11.75	11.75	2.00	1.50
08 Seacoast Mental Health Center	2.00	2.00	5.00	6.00	2.00	2.00
09 Community Partners	2.63	2.63	5.05	5.10	0.68	0.38
10 Center for Life Management	3.00	4.00	7.00	8.00	0.30	0.30
Total	**40.60**	**42.40**	**88.15**	**88.60**	**14.58**	**15.08**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health CMHC ACT Staffing Census Based on CMHC self-report.

Notes: Data compiled 04/20/2020; for 2b: the Staff Competency values reflect the sum of FTEs trained to provide each service type. These numbers are not a reflection of the services

delivered, but rather the quantity of staff available to provide each service. If staff are trained to provide multiple service types, their entire FTE value is credited to each service type.

3a. Community Mental Health Center Services: Annual Adult Supported Employment Penetration Rates for Prior 12-Month Period

Community Mental Health Center	12 Month Period Ending March 2020			Penetration Rate for Period Ending December 2019
	Supported Employment Clients	Total Eligible Clients	Penetration Rate	
01 Northern Human Services	189	1,330	14.2%	15.0%
02 West Central Behavioral Health	138	623	22.2%	20.1%
03 Lakes Region Mental Health Center	216	1,358	15.9%	19.6%
04 Riverbend Community Mental Health Center	304	1,879	16.2%	17.4%
05 Monadnock Family Services	58	1,089	7.3%	6.2%
06 Greater Nashua Mental Health	256	1,868	15.1%	13.0%
07 Mental Health Center of Greater Manchester	1,513	3,654	41.7%	40.5%
08 Seacoast Mental Health Center	737	2,036	39.0%	34.2%
09 Community Partners	90	767	11.7%	10.1%
10 Center for Life Management	187	1,139	16.4%	18.0%
Total Unique Clients	**3,679**	**15,501**	**23.7%**	**23.7%**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 04/21/2020

3b. Community Mental Health Center Clients: Adult Employment Status – Total

Reported Employment Status Begin Date: 1/01/2020 End Date: 3/31/2020 Employment Status Update Overdue Threshold: 105 days	Northern Human Services	West Central Behavioral Health	Lakes Region Mental Health Center	Riverbend Community Mental Health	Monadnock Family Services	Greater Nashua Mental Health	Mental Health Center of Greater Manchester	Seacoast Mental Health Center	Community Partners	Center for Life Management	Statewide Total or Mean Percentage	Previous Quarter Statewide Total or Mean Percentage October - December 2019
Updated Employment Status:												
Full time employed now or in past 90 days	63	34	29	113	54	103	272	221	45	71	1,005	**956**
Part time employed now or in past 90 days	144	54	251	315	140	240	363	257	69	161	1,994	**1,938**
Unemployed	180	106	34	87	134	763	939	104	144	490	2,981	**2,979**
Not in the Workforce	524	155	422	958	466	278	564	819	266	132	4,584	**4,557**
Status is not known	6	49	227	51	4	76	83	2	18	49	565	**464**
Total of Eligible Adult CMHC Clients	**917**	**398**	**963**	**1,524**	**798**	**1,460**	**2,221**	**1,403**	**542**	**903**	**11,129**	**10,894**
Previous Quarter: Total of Eligible Adult CMHC Clients	**944**	**412**	**930**	**1,485**	**801**	**1,468**	**2,202**	**1,274**	**512**	**866**		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	6.9%	8.5%	3.0%	7.4%	6.8%	7.1%	12.2%	15.8%	8.3%	7.9%	**9.0%**	**7.3%**
Part time employed now or in past 90 days	15.7%	13.6%	26.1%	20.7%	17.5%	16.4%	16.3%	18.3%	12.7%	17.8%	**17.9%**	**16.5%**
Unemployed	19.6%	26.6%	3.5%	5.7%	16.8%	52.3%	42.3%	7.4%	26.6%	54.3%	**26.8%**	**19.5%**
Not in the Workforce	57.1%	38.9%	43.8%	62.9%	58.4%	19.0%	25.4%	58.4%	49.1%	14.6%	**41.2%**	**42.3%**
Status is not known	0.7%	12.3%	23.6%	3.3%	0.5%	5.2%	3.7%	0.1%	3.3%	5.4%	**5.1%**	**0.3%**
Percentage by Timeliness of Employment Status Screening:												
Update is Current	59.0%	44.2%	70.4%	87.3%	66.2%	97.3%	90.5%	93.4%	60.5%	99.9%	**82.9%**	**78.6%**
Update is Overdue	41.0%	55.8%	29.6%	12.7%	33.8%	2.7%	9.5%	6.6%	39.5%	0.1%	**17.1%**	**21.4%**
Previous Quarter: Percentage by Timeliness of Employment Status Screening:												
Update is Current	60.6%	42.5%	73.7%	84.2%	56.9%	96.6%	91.5%	95.2%	84.6%	99.9%		
Update is Overdue	39.4%	57.5%	26.3%	15.8%	43.1%	3.4%	8.5%	4.8%	15.4%	0.1%		

3c. Community Mental Health Center Clients: Adult Employment Status – Recent Users of Supportive Employment Services (At Least One Billable Service in Each of Month of the Quarter)

Supported Employment Cohort Reported Employment Status Begin Date: 1/01/2020 End Date: 3/31/2020	**Northern Human Services**	**West Central Behavioral Health**	**Lakes Region Mental Health Center**	**Riverbend Community Mental Health**	**Monadnock Family Services**	**Greater Nashua Mental Health**	**Mental Health Center of Greater Manchester**	**Seacoast Mental Health Center**	**Community Partners**	**Center for Life Management**	**Statewide Total or Mean Percentage**	**Previous Quarter Statewide Total or Mean Percentage October-December 2019**
Updated Employment Status:												
Full time employed now or in past 90 days	1	3	0	4	0	5	9	0	1	4	**27**	**21**
Part time employed now or in past 90 days	14	7	13	23	4	21	31	13	5	27	**158**	**167**
Unemployed	12	9	4	18	3	19	27	14	5	16	**127**	**92**
Not in the Workforce	10	0	7	3	4	10	9	19	3	2	**67**	**69**
Status is not known	0	3	8	2	0	3	1	0	0	0	**17**	**13**
Total of Supported Employment Cohort	**37**	**22**	**32**	**50**	**11**	**58**	**77**	**46**	**14**	**49**	**396**	**362**
Previous Quarter: Total of Supported Employment Cohort	**32**	**19**	**51**	**42**	**17**	**45**	**76**	**31**	**8**	**41**		

Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	2.7%	13.6%	0.0%	8.0%	0.0%	8.6%	11.7%	0.0%	7.1%	8.2%	6.8%	**5.8%**
Part time employed now or in past 90 days	37.8%	31.8%	40.6%	46.0%	36.4%	36.2%	40.3%	28.3%	35.7%	55.1%	39.9%	**46.1%**
Unemployed	32.4%	40.9%	12.5%	36.0%	27.3%	32.8%	35.1%	30.4%	35.7%	32.7%	32.1%	**25.4%**
Not in the Workforce	27.0%	0.0%	21.9%	6.0%	36.4%	17.2%	11.7%	41.3%	21.4%	4.1%	16.9%	**19.1%**
Status is not known	0.0%	13.6%	25.0%	4.0%	0.0%	5.2%	1.3%	0.0%	0.0%	0.0%	4.3%	**3.6%**

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Note 3b-c: Data extracted 4/21/2020. Updated Employment Status refers to CMHC-reported status and reflects the most recent update. Update is Current refers to employment status most recently updated within the past 105 days. Update is Overdue refers to employment status most recently updated in excess of 105 days. Actual client employment status may have changed since last updated by CMHC in Phoenix. Employed refers to clients employed in a competitive job that has these characteristics: exists in the open labor market, pays at least a minimum wage, anyone could have this job regardless of disability status, job is not set aside for people with disabilities, and wages (including benefits) are not less than for the same work performed by people who do not have a mental illness. Full time employment is 20 hours and above; part time is anything 19 hours and below. Unemployed refers to clients not employed but are seeking or interested in employment. Not in the Workforce are clients who are homemakers, students, retired, disabled, hospital patients or residents of other institutions, and includes clients who are in a sheltered/non-competitive employment workshop, are otherwise not in the labor force, and those not employed and not seeking or interested in employment. Unknown refers to clients with an employment status of "unknown," without a status reported, or with an erroneous status code in Phoenix.

3d. Community Mental Health Center Services: Supported Employment Waiting List

As of 3/31/2020						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180+ days**
54	11	15	28	n/a	n/a	n/a

Data Source: BMHS Report.

Notes: Data compiled 04/20/2020. Total days waiting are calculated for all individuals waiting when data collection began on January 1, 2020.

4a. New Hampshire Hospital: Adult Census Summary

Measure	January – March 2020	October -December 2019
Admissions	218	235
Mean Daily Census	159	160
Discharges	213	239
Median Length of Stay in Days for Discharges	17.0	15.0
Deaths	0	0

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4a: 04/24/2020; Mean Daily Census includes patients on leave and is rounded to nearest whole number.

4b. New Hampshire Hospital: Summary Discharge Location for Adults

Discharge Location	January - March 2020	October – December 2019
CMHC Group Home	5	6
Discharge/Transfer to IP Rehab Facility	6	9
Glencliff Home for the Elderly	5	1
Home - Lives Alone	62	68
Home - Lives with Others	93	99
Homeless Shelter/ No Permanent Home	4	14
Hotel-Motel	7	3
Jail or Correctional Facility	3	7
Nursing Home	4	3
Other	6	4
Peer Support Housing	0	1
Private Group Home	2	3
Secure Psychiatric Unit - SPU	0	1
Unknown	16	20

4c. New Hampshire Hospital: Summary Readmission Rates for Adults

Measure	January – March 2020	October – December 2019
30 Days	6.9% (15)	6.8% (16)
90 Days	12.4% (27)	17.9% (42)
180 Days	21.1% (46)	23.0% (54)

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4b-c: Data compiled 04/24/2020; readmission rates calculated by looking back in time from admissions in study quarter. 90 and 180 day readmissions lookback period includes readmissions from the shorter period (e.g., 180 day includes the 90 and 30 day readmissions); patients are counted multiple times – once for each readmission; the number in parentheses is the number of readmissions.

5a. Designated Receiving Facilities: Admissions for Adults

Designated Receiving Facility	January - March 2020		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	61	53	114
Cypress Center	45	141	186
Portsmouth	70	263	333
Elliot Geriatric Psychiatric Unit	5	47	52
Elliot Pathways	42	65	105
Total	**223**	**569**	**792**

Designated Receiving Facility	October - December 2019		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	61	35	96
Cypress Center	41	134	175
Portsmouth	84	266	350
Elliot Geriatric Psychiatric Unit	5	58	63
Elliot Pathways	40	60	100
Total	**231**	**553**	**784**

5b. Designated Receiving Facilities: Mean Daily Census for Adults

Designated Receiving Facility	January - March 2020	October - December 2019
Franklin	10.6	10.6
Cypress Center	13.7	13.4
Portsmouth	29.2	31.8

Elliot Geriatric Psychiatric Unit	20.5	23.7
Elliot Pathways	12.0	9.5
Total	**86.1**	**89.0***

*Revisions to Prior Period: *Total was miscalculated.*

5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	January - March 2020	October - December 2019
Franklin	110	102
Manchester (Cypress Center)	207	198
Portsmouth	327	353
Elliot Geriatric Psychiatric Unit	71	60
Elliot Pathways	119	123
Total	**834**	**836**

5d. Designated Receiving Facilities: Median Length of Stay in Days for Discharges for Adults

Designated Receiving Facility	January - March 2020	October - December 2019
Franklin	6	7
Manchester (Cypress Center)	5	5
Portsmouth	6	6
Elliot Geriatric Psychiatric Unit	20	25
Elliot Pathways	8	7
Total	**6**	**7**

5e. Designated Receiving Facilities: Discharge Location for Adults

Designated Receiving Facility	January - March 2020						
	Assisted Living / Group Home	Deceased	DRF*	Home	Other Hospital	NH Hospital	Other
Franklin	0	0	0	101	0	3	6
Manchester (Cypress Center)	0	0	7	197	0	0	3
Portsmouth Regional Hospital	0	0	1	220	0	2	104
Elliot Geriatric Psychiatric Unit	24	0	0	16	0	0	31
Elliot Pathways	0	0	2	98	0	0	19
Total	**24**	**0**	**10**	**632**	**0**	**5**	**163**
Designated Receiving Facility	**October – December 2019**						
	Assisted Living / Group Home	**Deceased**	**DRF***	**Home**	**Other Hospital**	**NH Hospital**	**Other**
Franklin	0	0	0	98	0	3	1
Manchester (Cypress Center)	0	0	6	185	0	0	7
Portsmouth Regional Hospital	0	0	4	269	0	4	76
Elliot Geriatric Psychiatric Unit	12	0	1	13	0	0	34
Elliot Pathways	0	0	3	111	0	0	9
Total	**12**	**0**	**14**	**676**	**0**	**7**	**127**

**Dispositions to 'DRF' represent a change in legal status from Voluntary to Involuntary within the DRF.*

5f. Designated Receiving Facilities: Readmission Rates for Adults

Designated Receiving Facility	January - March 2020		
	30 Days	90 Days	180 Days
Franklin	3.5% (4)	6.1% (7)	7.8% (9)
Manchester (Cypress Center)	3.5% (7)	5.0% (10)	8.5% (17)
Portsmouth	9.7% (33)	19.2% (65)	23.0% (78)
Elliot Geriatric Psychiatric Unit	9.4% (5)	11.3% (6)	18.9% (10)
Elliot Pathways	9.7% (11)	14.2% (16)	15.9% (18)
Total	**7.3% (60)**	**12.7% (104)**	**16.1% (132)**
Designated Receiving Facility	**October – December 2019**		
	30 Days	**90 Days**	**180 Days**
Franklin	3.1% (3)	6.2% (6)	9.3% (9)
Manchester (Cypress Center)	10.3% (20)	13.9% (27)	21.1% (41)
Portsmouth	7.5% (28)	8.8% (33)	15.3% (57)
Elliot Geriatric Psychiatric Unit	5.7% (4)	7.1% (5)	8.6% (6)
Elliot Pathways	3.9% (4)	5.8% (6)	8.7% (9)
Total	**7.0% (59)**	**9.2% (77)**	**14.6% (122)**

Revisions to Prior Period: None.

Data Source: NH DRF Database.

Notes: Data compiled 05/06/2020.

6. Glencliff Home: Census Summary

Measure	January – March 2020	October - December 2019
Admissions	9	0
Average Daily Census	111	111
Discharges	2 (One resident discharged to a 3 bed Medical Model Group Home and one resident discharged to home with Family)	0
Individual Lengths of Stay in Days for Discharges	(393 and 762)	N/A
Deaths	0	4
Readmissions	0	0
Mean Overall Admission Waitlist	26	29

Revisions to Prior Period: None.

Data Source: Glencliff Home.

Notes: Data Compiled 05/11/2020; Mean rounded to nearest whole number; Active waitlist patients have been reviewed for admission and are awaiting admission pending finalization of paperwork and other steps immediate to admission.

7. NH Mental Health Client Peer Support Agencies: Census Summary

Peer Support Agency	January – March 2020		October - December 2019	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**224**	**44**	**248**	**28**
Conway	42	13	49	9
Berlin	105	7	114	9
Littleton	44	11	48	10
Colebrook	33	13	37	n/a*
Stepping Stone Total	**346**	**17**	**357**	**20**
Claremont	241	13	247	16
Lebanon	105	4	110	4
Cornerbridge Total	**91**	**14**	**147**	**15**
Laconia	25	6	37	6
Concord	58	6	93	6
Plymouth Outreach	8	2	17	3
MAPSA Keene Total	**42**	**19**	**85***	**19**
HEARTS Nashua Total	**400**	**36**	**409***	**33**
On the Road to Recovery Total			**152**	**11**

Peer Support Agency	January – March 2020		October - December 2019	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
	157	**10**		
Manchester	75	5	86	5
Derry	82	5	66	6
Connections Portsmouth Total	**82**	**14**	**89**	**14**
TriCity Coop Rochester Total	**216**	**26**	**252**	**23**
Total	**1,558**	**170**	**1,739***	**152***

Revisions to Prior Period: Corrected data indicated by (*).

Data Source: Bureau of Mental Health Services and Peer Support Agency Quarterly Statistical Reports.

Notes: Data Compiled 05/07/2020; Average Daily Visits are not applicable for Outreach Programs.

8. Housing Bridge Subsidy Program: Summary of Individuals Served to Date

Subsidy	January – March 2020 Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	872	50	922
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	163	16	179
Subsidy	**October - December 2019** **Total individuals served at start of quarter**	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	829	43	872
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	151	12	163

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 03/31/2020. Figures at start and end of each quarter are cumulative total of individuals served since CMHA quarterly reporting began in 2015.

8a. Housing Bridge Subsidy Program: Current Census of Units/Individuals with Active Funding Status

Measure	As of 3/31/2020	As of 12/31/2019
Rents Currently Being Paid	327	340
Individuals Enrolled and Seeking Unit for Bridge Lease	94	54
Total	**421**	**394**

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 03/31/2020; all individuals currently on Bridge Program are intended to transition from the program to other permanent housing.

8b. Housing Bridge Subsidy Program: Clients Linked to Mental Health Care Provider Services

Measure	As of 3/31/2020	As of 12/31/2019
Housing Bridge Clients Linked	348/421 (83%)	358/394 (91%)

Data source: Bureau of Mental Health Services data, Phoenix 2, and Medicaid claims.

Notes: Data compiled 04/28/2020; "Housing Bridge Clients Linked" refers to Housing Bridge clients who received one or more mental health services within the previous 3 months, documented as a service or claim data found in Phoenix or the Medicaid Management Information System.

8c. Housing Bridge Subsidy Program: Density of HBSP Funded Units at Same Property Address*

Number of HBSP Funded Unit(s)* at Same Address	Frequency as of 3/31/2020	Frequency as of 12/31/2019
1	279	276
2	14	18
3	2	4
4	2	2
5	0	0
6	0	0
7	0	0
8 or more	1	1

*All units are individual units; property address may include multiple buildings, such as apartment complexes.

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health data compiled by Office of Quality Assurance and Improvement.

Notes: Data Compiled 03/31/2020.

8d. Housing Bridge Subsidy Program: Applications

Measure	January - March 2020	October - December 2019
Applications Received During Period	74	59
Point of Contact for Applications Received	CMHCs 63; NHH 11	CMHCs 51; NHH 8
Applications Approved	104	42
Applications Denied	0	0
Denial Reasons	NA	NA
Applications in Process at End of Period	49	79*

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

*Notes: Data Compiled 03/31/2020. *13 applications with incomplete required additional documentation were withdrawn from the processing queue by the applicant or referring agent. The reasons provided for withdrawal include: received other housing or vouchers (3), incarceration (1), ineligibility (4), unable to locate applicant (4), and higher level of care was needed (1).*

8e. Housing Bridge Subsidy Program: Terminations

Type and Reason	January – March 2020	October - December 2019
Terminations – DHHS Initiated	2	0
Over Income	NA	NA
Exited Program – Client Related Activity	25	23
Voucher Received	16	16
Deceased	2	2
Over Income	4	0
Moved Out of State	1	2
Declined Subsidy at Recertification	1	0
Higher Level of Care Accessed	1	2
Other Subsidy Provided	0	0
Moved in with family	0	1
Total	**27**	**23**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 03/31/2020.

8f. Housing Bridge Subsidy Program: Application Processing Times

Average Elapsed Time of Application Processing (calendar days)*	January - March 2020	October - December 2019
Completed Application to Determination	1	1

Approved Determination to Funding Availability**	41	164
Referred to Vendor with Funded HB Slot	1	1
Leased Unit Secured	30***	18

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

Notes: Data Compiled 03/31/2020.

**Elapsed time measure reporting implemented 10/01/18 and applies to any application received on or after that date.*

***Average calculated on 50 applications approved for which funding was made available in the quarter.*

****Average calculated on 3 units leased during the quarter.*

9. Housing Bridge Subsidy Program Waitlist: Approved Applications

As of 3/31/2020							
Time on List							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
49	12	19	10	8	0	0	0
As of 12/31/2019							
Time on List							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
25	18	4	0	1*	0	1*	1

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

*Notes: Data Compiled 03/31/2020. *Indicates hospitalized individuals who were not medically cleared for discharge as of 12/31/19 but for whom an HBSP subsidy has been approved, pending discharge*

10. Supported Housing Subsidy Summary

	January - March 2020	**October - December 2019**
Subsidy	**Total subsidies by end of quarter**	**Total subsidies by end of quarter**

Housing Bridge Subsidy:	Units Currently Active	327	340
	Individuals Enrolled and Seeking Unit for Bridge Lease	94	54
Section 8 Voucher (NHHFA):	Transitioned from Housing Bridge*	177	163
	Not Previously Receiving Housing Bridge	3	2
811 Units:	PRA	75	60
	Mainstream	44	44
Other Permanent Housing Vouchers (HUD, Public Housing, VA)		5	5
Total Supported Housing Subsidies		**725**	**668**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 03/31/2020; Section 8 Voucher Not Previously Receiving Housing Bridge are CMHC clients that received a Section 8 Voucher without previously receiving a Housing Bridge subsidy; 811 Units (PRA and Mainstream) are CMHC clients or CMHA target population members that received a PRA or Mainstream 811 funded unit with or without previously receiving a Housing Bridge subsidy; Other Permanent Housing Vouchers (HUD, Public Housing, VA) are CMHC clients that received a unit funded through other HUD or Public Housing sources with or without previously receiving a Housing Bridge subsidy.

**These counts are cumulative; increasing over time since originally reporting this data within the CMHA Quarterly Data Report.*

11a. Mobile Crisis Services and Supports for Adults: Riverbend Community Mental Health Center

Measure	January 2020	February 2020	March 2020	January – March 2020	October - December 2019
Unique People Served in Month	215	199	199	531	516
Services Provided by Type					
Case Management	0	0	0	0	0
Crisis Apartment Service	0	0	0	0	0
Crisis Intervention Services	10	2	8	20	43
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	42	36	38	116	149
Office-Based Urgent Assessments	39	20	18	77	136
Other	0	0	0	0	0
Peer Support	0	0	0	0	0
Phone Support/Triage	378	413	382	1,173	1,139
Psychotherapy	0	0	0	0	0
Referral Source					
CMHC Internal	20	17	17	54	52
Emergency Department	4	7	7	18	10
Family	22	20	26	68	77

Measure	January 2020	February 2020	March 2020	January – March 2020	October - December 2019
Friend	2	5	6	13	8
Guardian	26	20	13	59	43
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	11	4	5	20	22
Other	6	2	5	13	5
Police	9	7	7	23	26
Primary Care Provider	10	8	5	23	20
Self	92	102	97	291	341
School	13	7	11	31	26
Crisis Apartment					
Apartment Admissions	25	17	15	57	81
Apartment Bed Days	98	82	65	245	364
Apartment Average Length of Stay	3.9	4.8	4.3	4.3	4.5
Law Enforcement Involvement	10	15	20	45	26
Hospital Diversions Total	141	115	127	383	483

Revisions to Prior Period: None.

Data Source: Riverbend CMHC submitted report.

Notes: Data Compiled 04/09/2020; reported values other than the Unique People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

11b. Mobile Crisis Services and Supports for Adults: Mental Health Center of Greater Manchester

Measure	January 2020	February 2020	March 2020	January – March 2020	October - December 2019
Unique People Served in Month	251	233	266	618	604
Services Provided by Type					
Case Management	39	33	19	91	84
Crisis Apartment Service	16	12	6	34	35
Crisis Intervention Service	91	80	71	242	254
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	7	4	4	15	7
Mobile Community Assessments	104	106	80	290	303
Office-Based Urgent Assessments	10	23	21	54	65
Other	270	234	277	781	735
Peer Support	22	13	7	42	83
Phone Support/Triage	528	514	523	1,565	1,482
Psychotherapy	4	0	5	9	11
Referral Source					
CMHC Internal	6	2	4	12	19
Emergency Department	2	0	0	2	2
Family	43	60	45	148	136

Friend	2	9	8	19	5
Guardian	6	5	5	16	15
MCT Hospitalization	6	7	10	23	0
Mental Health Provider	17	5	8	30	39
Other	52	37	40	129	148
Police	63	66	75	204	225
Primary Care Provider	14	16	6	36	40
Self	157	155	156	468	412
School	0	0	0	0	0
Crisis Apartment					
Apartment Admissions	9	6	2	17	18
Apartment Bed Days	28	18	7	53	72
Apartment Average Length of Stay	3.1	3.0	3.5	3.1	4.0
Law Enforcement Involvement	63	66	75	204	225
Hospital Diversion Total	373	366	349	1,088	1,086

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Notes: Data Compiled 04/30/2020; reported values other than the Unduplicated People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

11c. Mobile Crisis Services and Supports for Adults: Harbor Homes

Measure	January 2020	February 2020	March 2020	January – March 2020	October - December 2019
Unique People Served in Month	134	122	116	333	368
Services Provided by Type					
Case Management	12	18	21	51	83
Crisis Apartment Service	103	96	123	322	289
Crisis Intervention Services	0	0	0	0	0
ED Based Assessment	4	4	4	12	17
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	68	63	79	210	189
Office-Based Urgent Assessments	43	29	19	91	104
Other	0	0	0	0	0
Peer Support	100	69	54	223	168
Phone Support/Triage	133	130	122	385	463
Psychotherapy	4	0	0	4	16
Referral Source					
CMHC Internal	12	6	6	24	28
Emergency Department	3	0	0	3	7
Family	11	8	4	23	64
Friend	4	0	5	9	12

Guardian	0	0	0	0	0
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	7	5	4	16	23
Other	93	93	85	271	281
Police	4	2	6	12	17
Primary Care Provider	2	2	5	9	7
Self	33	47	34	114	155
Schools	16	9	9	34	35
Crisis Apartment					
Apartment Admissions	22	15	19	56	48
Apartment Bed Days	121	87	88	296	252
Apartment Average Length of Stay	5.5	5.8	4.6	5.3	5.3
Law Enforcement Involvement	0	0	0	0	0
Hospital Diversion Total	227	198	192	617	612

Revisions to Prior Period: None.

Data Source: Harbor Homes submitted data.

Notes: Data Compiled 04/14/2020; reported values other than the Unique People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.